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ORIGINAL ARTICLE

An international survey in postgraduate training in Oral Medicine

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OBJECTIVES: The aim of this preliminary study was to investigate postgraduate Oral Medicine training worldwide and to begin to identify minimum requirements and/or core content for an International Oral Medicine curriculum.

MATERIALS AND METHODS: Countries where there was believed to be postgraduate training in Oral Medicine were identified by the working group. Standardized emails were sent inviting participants to complete an online survey regarding the scope of postgraduate training in Oral Medicine in their respective countries.

RESULTS: We received 69 total responses from 37 countries. Of these, 22 countries self-identified as having postgraduate Oral Medicine as a distinct field of study, and they served as the study group. While there is currently considerable variation among Oral Medicine postgraduate training parameters, there is considerable congruency in clinical content of the Oral Medicine syllabi. For example, all of the training programs responded that they did evaluate competence in diagnosis and management of oral mucosal disease.

CONCLUSIONS: This preliminary study provides the first evidence regarding international Oral Medicine postgraduate training, from which recommendations for an international core curriculum could be initiated. It is through such an initiative that a universal clinical core syllabus in postgraduate Oral Medicine training may be more feasible.

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Introduction

The definition and scope of Oral Medicine as a speciality has differences worldwide. The definition of the speciality is important in determining how the training is implemented within a country. The British Society of Oral Medicine defines it as 'the speciality of dentistry concerned with the oral health of patients with chronic, recurrent and medically related disorders of the oral and maxillofacial region, and with their diagnosis and nonsurgical management' (http://www.bsom.org.uk). In North America, Oral Medicine is defined as 'the specialty of dentistry concerned with the oral healthcare of medically complex patients and with the diagnosis and non-surgical management of medically related disorders or conditions affecting the oral and maxillofacial region' (http://www.aaom.com).

These two examples demonstrate significant differences in the definition of Oral Medicine and this in turn likely affects each country's curriculum for speciality training. A curriculum can be defined as 'An educational plan that spells out which goals and objectives should be achieved, which topics should be covered and which methods are to be used for learning, teaching and evaluation.' (Wojtczak, 2002). Healthcare curriculum should be 'up-to-date, fit for purpose and relevant to the population it serves whatever that population might be, worldwide.' (McHarg and Kay, 2009).

Coles explains the difference between a curriculum and a syllabus: 'A curriculum is more than a list of topics to be covered by an educational program, for which the more commonly accepted word is a "syllabus".' (Coles, 2003).

The WWOM V working group undertook a broadly scoped survey to determine the similarities and differences in postgraduate Oral Medicine training

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(internationally). We could find no published data that explores the scope of such training in different countries.

There are several reports in the dental literature that support the educational value of a unified core curriculum. (Iacopino and Taft, 2007) Our primary goal in this preliminary study was to identify from the responding programs the minimum requirements, training parameters and core content in Oral Medicine. Our secondary goal is to develop a syllabus for an international Oral Medicine curriculum.

Aims

The aims of this study were to: investigate how postgraduate Oral Medicine training is recognized and defined; to detail the scope of Oral Medicine training, including similarities and differences between training parameters and to identify the minimum requirements and/or core content for an international Oral Medicine curriculum.

Methods

The survey was constructed from existing basic standards in postgraduate Oral Medicine training in the US and UK (http://www.ada.org and http://www.gdcuk.org), and divided into three sections; demographics, training parameters, and syllabi content. Most questions were of the closed response format although the demographic section had a free text response format. A copy of the questionnaire can be obtained from the corresponding author.

Survey questionnaires were distributed in the summer of 2010 to recognized experts in countries where it was perceived that there was postgraduate training in Oral Medicine. Contacts in each of the 61 identified countries were asked to provide information on their postgraduate Oral Medicine training and to cascade the questionnaire to program directors where applicable. Standardized e-mail messages which linked to the formatted online survey (http://www.surveymonkey. com) were utilized for both the initial request and for subsequent follow-up reminders. Reminders were sent out every 2 weeks until either a response was received or data collection ended.

Survey responses were divided into two groups: (1) program that self-identified postgraduate Oral Medicine training as a distinct field of study, and (2) those programs in which postgraduate Oral Medicine training was not a distinct field of study or was in the planning stage. Those countries with Oral Medicine as a distinct field became the study group for data analysis. Data were analyzed by the individual country, and any conflicts within a country were resolved by follow-up e-mail or personal communication.

Results

Demographics

A total of 69 responses were received from 37 individual countries. Only 46 (66.7%) were fully completed leading



 $\ensuremath{\textit{Figure 1}}$ Number of countries responding by continental geographic distribution

to partial data sets from 23 (33.3%). Eleven countries gave multiple responses. The majority of responses were from those who identified themselves as dental schoolbased (65.2%) and a smaller percentage represented specialist societies (20.3%) 14.9% of respondents identified with both a dental school and a hospital. Figure 1 details the number of countries by continent from which responses were received.

Oral Medicine training is a distinct field of study in 22 countries although for eight, Oral Medicine is not a recognized speciality (Table 1). In nine of these countries (41%), Oral Medicine is not a stand-alone field but is combined with another distinct field of study/speciality (Figure 2). The majority are with other dental fields, three with oral pathology and two each with oral diagnosis, radiology and special care dentistry, respectively. In one country, Oral Medicine is combined with a medical speciality (plastic surgery). Oral Medicine is a distinct field of study, a field combined with other training programs or is in the planning stages in at least 33 countries.

Training parameters

To analyze this section of the survey, the data set was restricted to countries which recognize postgraduate Oral Medicine training as a distinct field of study

Table 1 Countries with Oral Medicine training as a distinct field of study*

Oral Medicine is a recognized speciality	Oral Medicine is NOT a recognized speciality but a distinct field of study
Armenia	Finland
Australia	Greece
Canada	Ireland
Egypt	Italy
El Salvador	Peru
Iran	Spain
Israel	Sweden
Nigeria	USA
New Zealand	-
South Korea	-
Thailand	-
Turkey	-
UK	_
Venezuela	_

*Data represents only those countries represented by responses to the survey.



Figure 2 Specialities combined with Oral Medicine in countries where Oral Medicine is not a standalone speciality. Some countries had more than one speciality combination giving a total of 11 responses

(n = 22). Some countries that submitted multiple responses were reconciled into a single representative response for that country.

The reported postgraduate experience prior to entry into speciality training ranges from 0 to 3 years (Figure 3). The mandatory period of Oral Medicine speciality training ranges from 1 to 6 years but was most often 3 years in length (Figure 4). The shortest overall training was 1 year and the longest was 8 years. (21 countries answered this section of the survey).



Figure 3 Period of postgraduate training before entry to speciality training (n = 21)



Figure 4 Mandatory period of Oral Medicine postgraduate training required in years (n = 21)

In six training programs, clinical training was combined with a mandatory MSc, whereas only two combined training with a mandatory PhD. Ten countries offered an optional MSc program and 14 offered optional PhD programs. Two programs had no option for an MSc or PhD.

Sixty eight percent of training programs responded that the speciality is recognized by a national/state licensing board or similar body with 21% responding that the speciality is not formally recognized (11% did not know).

The data were analyzed for associations between training programs that are recognized by a licensing body and the process of accreditation. The 13 countries that had programs recognized by a licensing body were significantly more likely to have been accredited. (P = 0.02) (chi square: 5.23 with df = 1 and a level of significance of 0.05.) Programs that were recognized by a licensing body were also significantly more likely to have a competency framework or assessment in place. (P = 0.001) chi square: 9.9 with df = 1 and a level of significance of 0.05. Furthermore, licensed programs were significantly more likely to have a recognized certificate of completion of training. (P = 0.001) chi square: 15.4 with df = 1 and a level of significance of 0.05.

Syllabi content

Table 2 indicates some of the content areas that are evaluated for competence as part of postgraduate Oral Medicine training programs in the 20 countries with complete responses to this section. Whilst these differed slightly, there was broad agreement between syllabi. For example, 100% of the training programs responded that they did evaluate competence in diagnosis and management of oral mucosal disease and 90% assessed competence in diagnosis and management of oral/facial pain. In 75% of the countries that had postgraduate Oral Medicine training half of the content areas were in agreement.

Table 2 Percentage of countries covering specific Oral Medicine content areas

Content area	% Yes $(n = 20)$
Diagnosis and management of oral mucosal disease	100
Pharmacology	95
Diagnosis and management of salivary gland disorders	95
Diagnosis and oral/facial pain disorders	90
Oral pathology	85
Laboratory medicine (pertinent to oral disease)	85
General medicine	80
Advanced radiological assessment (appropriate ordering and interpretation)	80
Diagnosis and management of oral chemosensory disorders	75
Dental management of the medically complex patient	70
Training in imaging techniques (e.g., radiography, CT, or MRI)	60
Interventional techniques (e.g., sialography)	30

Discussion

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This preliminary study provides the first insights into how postgraduate Oral Medicine training is conducted around the world. It exists as a distinct field of study, a field combined with other training programs or is in the planning stages in at least 33 countries. There is, however, variation in Oral Medicine training throughout the world.

The length of Oral Medicine training varies significantly from 1 to 6 years. There are differences in the required periods spent in postgraduate training before entry into speciality training in Oral Medicine and also the length of time spent in this speciality training. Occasionally, the difference can be accounted for by the requirement to undertake a mandatory MSc or PhD.

Any time differential may need to be addressed or accounted for in the creation of an international curriculum. Time, however, may not be the correct parameter to be evaluated if an international curriculum is to be fulfilled. Content areas may more closely reflect the predictability of achieving an acceptable international curriculum in postgraduate Oral Medicine training.

As expected, those programs recognized by a licensing body were significantly more likely to be accredited, have a competency framework or formal assessment and have a certificate of training completion. In the UK, for example, the General Dental Council mission statement as a licensing body is to assure the quality of dental education and set standards of dental practice and conduct (http://www.gdc-uk.org).

As curricula in postgraduate Oral Medicine training are varied and quite detailed, it is difficult to capture their similarities and differences in one survey. This survey provides a starting point. There seems to be considerable congruency in clinical content of the syllabi and so a universal clinical core syllabus in postgraduate Oral Medicine training should be feasible.

Some limitations of this study include our inability to obtain contact details for appropriate individuals in some countries. Of those who were queried, only 67% of the surveys were completed in full, possibly due to language barriers.

Future directions for this study should attempt to engage countries that did not respond to this survey, and to re-engage countries that did respond with the aim of gaining greater insight into their existing curricula. The ultimate goal would be to produce a draft document offering guidance on specific curriculum development and validate this by international consensus.

Author contributions

Helen Rogers contributed by organising data collection, emailing key contacts for the survey and analyses of the data. She wrote the manuscript and co-ordinated subsequent comments and amendments from the WWOM group. Thomas Sollecito has contributed by organising and heading the World workshop on Oral Medicine (WWOM) group 7, designing the survey, analysing the data, critically revising the paper and approving the final version

David Felix has contributed by organising and heading the WWOM group 7, designing the survey, analysing the data, critically revising the paper and approving the final version.

Juan Yepes has contributed by helping in collecting the data, statistically analysing the results and approving the final version

Joseph DóAmbrosio has contributed by helping in the design, analysing the data, revising the final article and approving it prior to submission

Michele Williams has contributed by helping in the design, analysing the data, revising the final article and approving it prior to submission

Linda Prescott-Clements has contributed especially to the educational aspects of the survey and the subsequent paper. She has approved the final version

Tim Hodgson has contributed by helping in the design, analysing the data, revising the final article and approving it prior to submission

David Wray has contributed by helping in the design, analysing the data, revising the final article and approving it prior to submission. He sat on the steering committee for the WWOM.

Ross Kerr has contributed by helping in the design, analysing the data, revising the final article and approving it prior to submission. He sat on the steering committee for the WWOM.

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