

Dear Editor

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Dental schools across the world aim to prepare and train dental graduates to be competent and fit to practice independently. However, educators seem to differ in their objectives and ideals.

Globally, official documents on competencies for the new dental graduates were published – The American Dental Education Association (ADEA) approved competencies;¹ the Canadian dental programmes adopted a national consensus for competencies in 1994;² the General Assembly of the Association for Dental Education in Europe approved competencies for the European Dentist;³ and the Dental Council of New Zealand in 2012.⁴

For South Africa, the African Medical Education Directions for Specialists (AfriMEDS) core competency framework was adapted from the Canadian Medical Educational Directives for Specialists (CanMEDS) by the Health Professions Council of South Africa.⁵ The reason for the adoption and supplementary modification was to align the framework with the South African context and to be sufficiently generic to guide the training of all health professionals. Seven roles are included in AfriMEDS core competency framework (Health Care Practitioner, Communicator, Collaborator, Leader and Manager, Health Advocate, Scholar and Professional).⁵ As CanMEDS framework was initially developed for specialist training, the feasibility of “translation” of the core competencies for dental graduates requires deeper interrogation.

Reviewing the AfriMEDS roles requires innovative processes that should include stakeholders such as the regulatory body, academia, private and public sectors. It is unclear whether access to oral health care and oral health disease burden were considered when the seven roles were developed. Given that oral health is not set as a health priority in South Africa contributes to the complexity of the development and adoption of the AfriMEDS core competency framework for dental schools.

When reviewing these seven roles consideration should be given to the other local and international factors that impact the training of healthcare professionals in South Africa, including dentists. The local factors include the National Development Plan 2030;⁶ the inequity in the burden of disease;⁷⁻⁹ and the call by the National Department of Higher Education and Training for the decolonisation of curriculum in higher education.¹⁰ A major international factor is the

recommendation of the Commission on Education of Health Professionals for the 21st Century.¹¹

Giving due consideration to these local and international factors in the development of the competencies in undergraduate dental education in South Africa will be beneficial in raising the standard of oral health care in the country. For example, the call for decolonisation of curriculum acknowledges the inherent power relations in the production and dissemination of knowledge, and seeks to destabilise these, allowing new forms of knowledge which represent marginalised groups.¹²⁻¹³ Deconstructing the role of the oral health professional may bring a new perspective relative to our local context. In addition to these factors, COVID-19 and digital dentistry have impacted dental education and practice globally. For example, Ali *et al*¹⁴ reported that, compared to the educators, dental students considered online learning to be less interactive and preferred learning activities and all assessments to be delivered face to face. This underscores the need to adapt teaching practices to suit the learning needs of the students.

Similarly, Tukur *et al*¹⁵ reported that in South Africa, dental students' training is largely centred around clinical practice, despite evidence showing the students believe that leadership skills are imperative in their education. Could this be an opportune time to reconsider the competencies required for dental graduates in South Africa in the 21st century?

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