Adding value through a common learning platform: Oral Health education at Griffith University

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Abstract

Since the inception of oral health education in Australia, the specific professional groups within this area of health care have been provided with academic and technical training in distinct and separate settings. Teaching and learning has been conducted within distinct courses for the different disciplines. There have been varying levels of qualification and little recognition for the need for inter-professional communication and collaborative work. Common learning sets the scene for inter-professional collaboration between dentist, oral health therapist, oral hygienist, dental prosthetist and dental technologist. The objective of this paper is to investigate how the concept of common learning can add value to the teaching and learning experience within the discipline of oral health education at Griffith University. The change from these discrete teaching practices is now evident in the teaching and learning methodology being initiated at Griffith University, where the Dentistry and Oral Health School has introduced a suite of programs based on a collaborative curriculum. Further evidence on the lead role taken by Griffith University in dental education in Australia is provided by outlining the teaching and learning opportunities for the oral health team of professionals. The outcome of this integrated multidisciplinary teaching and learning approach highlights the benefits of effective teaching and learning in dental education. The curriculum promotes the building of respect and communication amongst peers. It maximises their knowledge base, thereby providing graduates with a platform of similar knowledge to foster engagement in collaboration and teamwork, as well as life-long learning and research.

Introduction

This paper examines the education of dental professionals where a common learning platform is viewed as a way in which a shared learning experience for students can achieve an interdisciplinary environment. This is promoted by a common curriculum and shared learning experiences. To date, dental education has been conducted at separate institutions and at varying academic levels (Hancock, 1993). Registration has been segregated with little common focus and there have been no obvious congenial common links between the groups. Healthcare provides the opportunity for a cooperative approach to oral health care, however the team approach as yet has not been fully embraced.

Malcolm Thomas (2003), in his writings of the history of dentistry, wrote that showmen in the late 19th century travelled the width and breadth of Queensland “performing dubious acts of dentistry upon willing participants.” Some of these “dentists” were apprenticed to professional dentists who had received a Diploma from the Australian College of Dentistry in Melbourne. It wasn’t until 1903 that the Dental Board of Queensland was created and regulation of the profession commenced. In 1935, The University of Queensland joined with the Brisbane Dental Hospital and the Dental Board of Queensland to teach and train dentists, who then entered the profession with a Diploma in Dental Studies.

Thomas reports in his text, A Century of Regulation 1902-2000 (2003), that Griffith University was approached in 1996 by dental prosthetists to develop an oral health-training program. The Dental Board of Queensland at the time thought this would duplicate the efforts of The University of Queensland and result in more trained personnel becoming available than could be reasonably absorbed into the profession. This
viewpoint did not reflect the reality of demand in Queensland for oral health services, and can be illustrated by the emergency visits evident throughout Australia (Figure 1). The demand for services increases as the population increases (Australian Bureau of Statistics, 2004).

![Figure 1: Visits for publicly funded “emergency” dental care from Australia’s National Oral Health Plan 2004 –2013. (2004)](image1)

**Education and registration of dental practitioners**

An issue that resided within the request to develop academic training for dental prosthetists was the fragmentation of education and regulations that controlled the skilled professionals working in the oral health profession. It was seen that if this issue was addressed, it could result in benefits to the delivery of oral health care to the Queensland population (National Health and Medical Research Council, 1993).

Registration of dentists has been in place for a century and in 2004 there are 2,153 Queensland registered dental practitioners, with 251 registered as dental specialists. The code of practice document from the Dental Board of Queensland states that dental therapists commenced working in Queensland in 1976 and Dental Hygienists in 1988 (Dental Board of Queensland, Code of Practice #1, 2004). Since June 2004, the latter two groups have become regulated under this board. The Dental Board reports there are currently 383 registered dental auxiliaries: 44 hygienists, 187 dental therapists and 152 oral health therapists in Queensland. A comparison of these figures is highlighted in Figure 2.
Figure 2: Registration numbers kindly provided by the Dental Technicians and Dental Prosthetists Board of Queensland and the Dental Board of Queensland, August 2004.

Registration of dental technicians has been in place since 1988, while dental prosthetists have been registered since 1992. Both of these groups are registered under the Dental Technicians and Dental Prosthetists Board of Queensland. Currently there are 709 dental technicians and 144 dental prosthetists registered (Figure 2).

Within this structure of registration as seen above, each of the oral health professional groups has a degree of isolation in a hierarchical setting. Changes to the education of practitioners could provide common links between the groups and a cooperative approach to oral health care and development of joint codes of practice.

The National Health and Medical Research Council in its report, *The Impact of Change in Oral Health Status on Dental Education, Workforce, Practices and Services in Australia* (1993), highlighted the consequences of an education system that involved universities, TAFE colleges, Health Departments, and the dental profession. One of the main consequences was a fragmentation of the industry which was seen as detrimental to a service where “dentist, therapist, hygienist and technician tend not to work collectively as members of a dental health team” (National Health and Medical Research Council, 1993).

**Dentistry and oral health at Griffith University**

To address the challenge posed by this report, Griffith University has taken a lead role in dental education in Australia by winning the support of the Federal Government to establish the first School of Dentistry and Oral Health in Australia. This School has introduced an all-embracing approach to the training of all professionals within the oral health profession. A cohesive service is seen as possible through a program of common
education, the creation of congenial links between the groups, and qualifications that hallmark the high standard required within all areas of the profession.

Within the oral health environment, education had previously positioned these service providers in "silos", with the potential for conflict within the oral health system. Griffith University has provided an improved education situation for oral health professionals as a whole through the introduction of an innovative curriculum. This curriculum is aligned to The Common Learning Project (The University of Newcastle Upon Tyne, 2002) initiative from the northeast of England, where practice-based inter-professional education for health and social care professionals is promoted. The aim of the project is "that students will develop ways to provide patients with the sort of seamless care envisaged by policymakers as being at the heart of a modernised health service" (The University of Newcastle Upon Tyne, 2002). By providing a common focus or problem, the professional groups will learn complementary knowledge, skills and attitudes to facilitate the inter-professional approach to patient care (Hughes, Hemingway & Smith, 2004).

Within the dynamics of common teaching and learning, the School of Dentistry and Oral Health at Griffith University (Gold Coast campus) has embarked on a collaborative approach. Students are provided with a solid foundation in health and human sciences, topped with a layer of communication and dental material science, and integrated with research, health-law and ethics. By developing a common knowledge, skill and attitude base, it will allow each cohort to communicate on a similar level and develop a mutual respect for each other. By establishing common goals and overlapping skills and knowledge, the students become familiar with the professional roles of each discipline (McCallin, 2001). This allows each group to reflect on what they bring to the learning (Glen & Reeves, 2003). Building collegiality at the education level will help to establish a team approach and respect within the oral health profession, thus reducing fragmentation. Evidence indicates that if these principles are applied in the first year of the educational program there is a greater opportunity to prevent misconceptions, negative attitudes and stereotyping toward each profession (Morrison et al. 2004). This in turn produces graduates who are willing and ready to work as a member of a multi-disciplinary team. West and Field (1995) found that their professional boundaries are flexible, therefore dialogue and interactions between health professionals regarding patient care outcomes is the common focus.

This collaborative method is promoted by the team approach within and surrounding the dentistry and oral health arena. Academics from distinct disciplines teach in the dentistry and oral health courses to provide experiential knowledge and skills. This multidisciplinary educational practice "contributes to an equitable standard of health care as well as to equal opportunities in education and employment" (Luciak-Donsberger, 2003). Not only is there a distinct team approach within the School of Dentistry and Oral Health, but also a collegial approach to teaching within the other Schools is established. For example, collaboration is occurring with engineering, nursing, pharmacy, physiotherapy and other schools within the health science area, all of whom play a critical role in developing an inter-professional curriculum. The outcome is familiarity within other professional areas and an acknowledgment of the relevance of other disciplines and skills. This collaborative approach includes staff from Griffith University library to enhance teaching and learning practices. The impact of these teaching practices will be evident through evaluation processes.

The collaborative teaching partnership is highlighted by the team approach to the presentation of course work in one of the third year courses. This approach promotes a collaborative and inclusive educational model that provides valuable learning and teaching experiences, as well as benefits to patient care. The academic staff are partnered by the librarian to present an integrated program encompassing: academic, technical, research, and information literacy education. The teaching team is founded on many of the guidelines offered by Ivey (2003) and incorporates a partnership based on a
good working relationship and shared goals. The collaborative approach commenced with the planning for the course and continues through the delivery stages to an evaluation process. The evaluation process includes questionnaires and interviews of both staff and students to ascertain the effectiveness of the collaborative approach to teaching and learning.

In addition, although the students will branch into their chosen fields of Dentistry, Oral Health Therapy, Technology or Prosthetics, they will have the opportunity to share learning together by studying within a multidisciplinary framework. Connecting knowledge to the context and building relationships within this environment brings a connection among the professionals and professions. Rather than learning in isolation, the interdisciplinary curriculum creates increased teaching and learning opportunities to expand perceptions and mindsets (Wilen et al. 2000). The common learning principles within dentistry and oral health at Griffith University are congruent with Pedersen and Easton’s (1995) themes to underpin a cooperative approach. The themes or principles identified include developing common goals, familiarity with defined roles, commitment to health care, building trust and respect through communication and developing competent and skilful work practices. These themes permeate the curriculum, adding value to the learning experience.

This integrated multidisciplinary teaching and learning approach builds respect and communication amongst peers, maximises the knowledge base and provides the graduates with a platform of similar knowledge to foster engagement in life-long learning and research. The academic program provides cohesion between all future providers of oral health. It needs to be remembered that historically, a hierarchy of services that includes the dentist, the hygienist and therapist, the technologist and the rarely mentioned prosthetist has provided oral health services. Each of these areas of service can be seen as having work opportunities in both the public and private sector, with each group having a niche within the profession. An outcome of the innovative academic program offered at Griffith University is the concept that all members of the oral health service are working as a collective team, thus adding value to the educational experience.

This integrated service is seen as beneficial to the oral health profession by providing the public with a service based on a multidisciplinary approach that maximises the knowledge base of all service providers and has the overall health of the patient as the key focus. With the Gold Coast continuing to be Australia’s fastest growing area of urbanisation (Australian Bureau of Statistics, 2004), it is predicted that this growth will bring extensive demands not only on infrastructure but also on the health service. It can be seen that the multidisciplinary approach to dental education will provide the base for a systematic approach to this health service not only in southeast Queensland, but to health service in general.

Page and Meerbeau’s (2004) evaluation of students’ reflection on a multi-professional education initiative in the United Kingdom supports this view. In that context, it was confirmed that the students from medicine and nursing felt they were on “equal footing” while developing a greater appreciation for professional viewpoints. Some students felt that by learning in a shared environment added “weight” to the course content. As a multidisciplinary approach to health care provision has become more accepted within health organisations, it is timely that students learn to function within a team environment.

Conclusion

At this stage of the common learning program it is evident that an evaluation process needs to be established to measure the effects of these changes and the impact on the oral health profession. Literature from the United Kingdom illustrates the benefits of the
common learning and the inter-professional approach to education (Barr & Goosey, 2002; Barr & Low, 2002; Glen & Reeves, 2003; Hughes et al. 2004; Morrison et al. 2004). The common learning curriculum promotes the building of respect and communication amongst peers. It maximises their knowledge base and thereby provides graduates with a platform of similar knowledge to foster engagement in collaboration, teamwork and also life-long learning and research. This approach achieves a collaborative and inclusive educational model that provides valuable learning and teaching experiences, and a long-term outcome of improved patient care. Griffith’s agenda is to deliver such benefits here in southeast Queensland and provide a model upon which others can build.

References


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