CHAPTER I

BACKGROUND AND RATIONALE

Chulalongkorn University founded its Faculty of Dentistry, the first dental school in Thailand, in 1940[1]. Since then, the Faculty has continuously developed its dental curriculum. The fifth and last major changes in the dental curriculum were in 1986 and the present curriculum has undergone only minor improvements[2]. A formative evaluation of the present curriculum was done in 1992[3]. The evaluation showed that the curriculum had too many subjects for dental students to study well and the sequences of a number of subjects being taught might not allow students to form coherent and systematic perception and ideas. Subsequent summative evaluation tried shortly afterwards failed to materialize probably due to flawed strategic planning and administration of the evaluation coupled with poor cooperation of the stakeholders.

Demographic and society shifts, changes in the structure and delivery of health care, changing patient expectations, health care reform, hospital accreditation, changes in the funding of health care services are external factors and the sources of stimulus to evaluate and reform the curriculum.

A variety of methods have been used to review the curriculum. One way is to use external yardsticks as a measure of the adequacy of the curriculum.

In Western Countries, especially the United States of America, the dental education has been shifted towards competency-based model. The

changes started in the 1980s. The 1984 report of the Pew Health Professions Commission [4] and the 1995 Institute of Medicine study[5] proposed reformation of curriculum content and modernization of teaching/learning methods. The recommendations argued for a learning environment that encouraged students to learn collaboratively, provided students with opportunities to practice application on newly acquired biomedical information by solving simulated or real patients problems, fostered close and longitudinal contact between instructors and small groups of students, and provided learners with continuous contact with patients, and their health problems throughout the educational program.

Many dental schools in the United States of America tried problem-based learning (PBL)[6-11]. The rationale was to enhance the relevance of the basic science curriculum, the integration of the clinical and basic sciences, and the infusion of active learning. PBL did not capture the imagination of the dental education community to the extent as it had in medical schools. Hendricson WD and Cohen PA highlighted four factors that might have contributed to PBL's failure to make significant inroads [12]. First, traditional PBL emphasized the formulation of a broad-spectrum differential diagnosis, followed by systematic data collection to rule out pathogenic options. At its heart, PBL was a detective game designed to help students identify problems, retrieve data, and ultimately solve the mystery. The PBL format, focusing on diagnosis, might not be ideally suited to the "traditional" dental school curriculum, which tended to emphasize the other end of the spectrum: treatment. The second factor related to how PBL had been used in the traditional dental curriculum. PBL had been added on top of already densely packed curriculum. The third factor was the concern of the faculty about the

time and effort-effectiveness. The last factor related to the back and forth nature of PBL. The process might appear messy and unproductive to dental faculty, who were used to the expert role rather than the facilitator role.

The competency-based curriculum for dental profession derived from the idea that dental curricula should be characterized in term of their impact on students, expressed as competencies, rather than discipline-based content. Instructional and behavioral objectives with content- and discipline-specific emphasis could be reframed into a new integrated curriculum design that would reinforce the relationship between the basic biomedical, clinical and behavioral sciences[13]. The goal of an academic program based on competency-based educational principles was to provide students with learning experiences that allowed the integrated development of the multiple components of competence, rather than the isolated development of subordinate skills, with assessment focusing on the student's ability to perform the generalized competency [14].

The first dental school to develop competencies statements was the University of Puerto Rico in 1987/88. Since then, probably half of U.S. dental schools have developed set of competencies to be used in various purposes The American Association of Dental Schools (AADS) took the lead in co-ordinating competency-based education in 1994. The House of Delegates adopted a position that curricula would be discussed in terms of competencies rather than continuing to develop the curriculum guidelines based on specific disciplines[15]. In 1997 the House of Delegates approved a prototype set of competencies for the new dentist [16]. In Canada, the National Dental Examining Board of Canada (NDEB) developed the competencies document as an examination blueprint for certifying graduates of accredited

faculties of dentistry in Canada[17]. Thematic network on European Dental Education provided a list of basic clinical competencies required of all newly graduated and/or newly registered dentists in the European Union[18].

The building of competency-based dental curriculum is based on developing competency statements that describe the dental graduates[19]. To develop competency statements, careful delineation of these components of dental practice is the first and most critical step in designing a competency-based curriculum. A variety of techniques are used to identify and validate competencies including expert panels, practitioner surveys, job and task analysis, critical incident techniques, the Delphi process and Health care needs[20]. These techniques, however, have some methodological problems, or take long survey period, and/or are costly to develop.

Looking forward to reforming the curriculum of the Faculty of Dentistry, Chulalongkorn University to be up to date and to meet the International standards, the author therefore proposes a study towards the opinions of the faculty staffs in relation to the competency statements. The study will sound out to the faculty staffs' opinions about the proposed competencies standards for the new dental graduates adapted from some of the latest American competencies standards for the new dentist as the instrument. As dental educators need to consider the opinions of the stakeholders as a part of any planning effort, the study will also sound out the opinions of the user, which include dental practitioners both in the government sector and the private sector.

To survey the opinions upon the competency statements adapted from documents already existed could be advantages for the Faculty staffs and dental practitioners who are not used to this format. The survey might

encourage the faculty to seriously examine the present curriculum and to initiate ideas for reforming curriculum.

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