Yours faithfully,

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Re: Aesthetic Facial Surgery

Sir,

We believe that Aesthetic Facial Surgery is not receiving the attention that it deserves from the Association and it is now the time to establish this as an important component of our training and clinical practice.

This is because of:

1. Increasing awareness and demand for training from our SpRs.
2. The Health Care Bill which came into force in April of this year will make it increasingly difficult for surgeons to enter the field of Cosmetic Surgery without some evidence of appropriate training.
3. Plastic Surgeons and in particular ENT Surgeons have organised training programmes and even a form of accreditation in Cosmetic Surgery. We as a specialty run the risk of being excluded.
4. We have a very laudable claim on Aesthetic Facial Surgery through Orthognathic Surgery and treatment of post-traumatic deformities.

If we accept that competent aesthetic training is essential as a core curriculum or as a specialised fellowship, then we need to create the environment for that to be made feasible. We suggest BAOMS should state its intention to develop training opportunities and a special sub group should be established to develop subspecialty specialisation.

As a start, one could commence with:

1. General knowledge and introduction in the 1–5 year training guide.
2. Recognised lectures and hands on courses be an annual event.
3. Trainers to be identified.
4. Some form of certification for this subspecialty.

We would welcome an open debate.

Yours sincerely

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Re: Training in Maxillofacial Surgery

Sir,

In the past, training was by apprenticeship. Today, it is a structured, didactic, uniform process, fixed in a discrete time period. The problem is how to acquire sufficient experience and clinical acumen in the reduced time available. We need to debate the scope of the speciality, the training method, trainer suitability, assessment and the exit examination.

The main areas of the speciality of Maxillofacial surgery are oncology, trauma, deformity and aesthetics, with contributions in oral medicine, temporomandibular joint disease and dentoalveolar surgery. Is there a need to expand the remit of the major categories, for example, include thyroid disorders, based on the premise that if we subspecialise, the case mix will be further limited for purposes of training? Many colleagues still feel uneasy about the concept of facial aesthetic surgery. In our opinion, the time has come to consider this as a major subspecialty.

One way of structuring the training is to have a nationally agreed training guide for years 1–5, based on: outpatients, ward management, operative skills and research, publications and presentations. This would go hand in hand with the exit examination assessment, which has comparable sections. A weekly consultant round and monthly grand round would give opportunities to the trainee to present a case and develop their presentation skills, as well as formulating a strategically focused management plan. The training guideline should have minimum requirements for each categorised procedure and the 'performed with supervision' section should be higher in number than the 'assisted' section in years 4 and 5. This requirement should be checked in the RITA assessment. Hospitals that can offer a suitable programme would be given training status. Another way to improve exposure is to recognise training centres abroad.

Should all NHS Consultants automatically be accepted as trainers, or should they first demonstrate a minimum standard of teaching ability? A trainer's portfolio should be a requirement of hospital accreditation and with this the culture that training comes free should be discarded. Trainers should be rewarded for their efforts. Currently, the number of trainers available is limited and either more consultants are required or clinical services need to be centralised.

Appropriate assessment of technical skill is another topic of debate. Computer-aided virtual reality[1] could provide an objective method of assessment. But, technical skill alone does not make a good clinician in the absence of clinical judgement. Opinion has been expressed that a satisfactory RITA assessment should be accepted as proof of skill in the exit examination. Others see the examination as a final exacting test of ability. We think that the time is right for a national debate.