Yours faithfully

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Re: Will Maxillofacial Surgeons Remain Dental Surgeons First?

The Calman reforms have led to a reduction in the length of all surgical training. Before the reforms, dental graduates had a shorter pathway than medical graduates to achieve maxillofacial consultant status, with exemptions from primary FRCS and 3-year medical courses. Now that 3-year dentistry courses for medical graduates have been established, medical graduates and dental graduates can complete their second degrees in the same length of time.

Furthermore, medical graduates with the MRCS diploma are exempted from parts A and B of the MFDS, whereas dental graduates with MFDS have no exemptions from the MRCS examinations. Dental graduates may need more time as senior house officers to take these extra examinations. This could lead to dental graduates taking longer time than medical graduates to achieve consultant status.

Traditionally, maxillofacial surgery has recruited the overwhelming majority of its trainees from dental graduates and has had close links with dental surgery. However, these recent developments in training make maxillofacial surgery far more attractive to medical graduates. Whether maxillofacial surgery continues to recruit the majority of its trainees form a dental background remains to be seen.

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Re: Training in Maxillofacial Surgery

Sir,

I read with interest the letter entitled: ‘Training in Maxillofacial Surgery’.

I must correct a number of factual inaccuracies. It is true to say the present system of training is more structured than earlier, but it is not true to describe the process as ‘a uniform process fixed in a discrete time period’. There remains much variation in both the range and quality of specialist training in the United Kingdom.

Overall, there has been an improvement in the quality of training. As a result, many more trainees are exposed to a wider range of surgery. Training is progressive, by which I mean, the trainee is gradually exposed to new aspects of the speciality in the capacity of assistant, moving on to performing and undertaking clinics and operating lists under varying degrees of supervision, and ultimately progressing to the position whereby they are judged competent to perform clinical duties with minimal supervision.

The assessment process culminating in the ‘RITA’ process, although imperfect, is a significant improvement over the ad hoc arrangements prevailing prior to the introduction of Calman training. When used effectively, this system permits the length and content of training for an individual to be determined flexibly according to the individual’s training needs.

The nationally agreed training guide, to which the authors refer, is available in the form of the curriculum. This is supplemented by the syllabus for the intercollegiate board examination. It should be noted that the curriculum is presently being revised as part of a major exercise undertaken by the Joint Committee for Higher Surgical Training (JCHST). It is envisaged that there will be a degree of consistency across all of the surgical specialities.

The debate over the scope of the speciality continues to be led by the Council of the British Association of Oral and Maxillofacial Surgeons (BAOMS), which has liased closely with the Curriculum and Competence Sub-committee of the Specialist Advisory Committee (SAC). It is important to understand that the scope of the speciality must be primarily driven by the health needs of the population, rather than by the desire of individuals to provide particular services.

With regard to the specific comments about facial aesthetic surgery, I would point out that this aspect of maxillofacial surgery is covered in the curriculum and is assessed as part of the intercollegiate board examination. It is true to say that training in this area is restricted by the availability of clinical cases within the public sector, nonetheless, the SAC has always taken a pragmatic view about transferable surgical skills and their applicability to facial aesthetic surgery. There is no objection in principle to trainees obtaining training in this (or any other area) in the private sector or abroad, provided that the training offered is progressive (culminating in trainees performing cases with minimal supervision) and to a standard comparable to that provided in the public sector. There has always been provision for trainees to seek training overseas for up to one year within the normal five-year continuum, subject to approval by the training programme director and SAC.

With regard to prescribing ‘minimum requirements for each categorised procedure’, this could lead to difficulties. The problem is that each case is unique, and trainees progress at different rates. A minimum could only be justified on the basis of a robust evidence base, and regrettably such evidence does not exist. The SAC does now possess considerable data showing the range of case-mix to which trainees are exposed during the continuum. It may be possible in the fullness of time to correlate volumes of procedures undertaken with outcomes but this is a long way off.