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The role of the dental degree in the UK Oral and Maxillofacial training pathway: is there a future without it?

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Oral and Maxillofacial Surgery (OMFS) is a surgical specialty with a rich history that can be traced back to ancient Egypt (2700 BC). Its origins in the UK date to the world wars of the last century, when it evolved from the pioneering work of dental surgeons who began to specialise in treating patients with complex jaw injuries. This background has afforded the field a proud and distinguished identity, and coupled with the requirement for all OMFS surgeons to be dual qualified in dentistry and medicine from the late 1980s has earned the discipline admiration and respect as an authority on conditions affecting the face, jaws and mouth. Over time, the surgical repertoire of the OMFS practitioner has expanded to include ever more areas of subspecialisation. Traditionally, trainees first studied dentistry, gained experience in hospital departments, and ultimately studied for a medical degree. This was followed by a comprehensive general and specialist surgical training programme. More recently, there has been an increase in the number of trainees entering OMFS training after first studying medicine[1]. Dual professional membership, with clear educational and training benefits, is a unique feature of OMFS, but it has ultimately led to concerns over the future of the specialty. Indeed, despite greater clarity and better defined pathways for training via medicine- and dentistry-first routes, competition in the specialty to 4.38 per place in 2018.

Barriers to training

Several barriers have been cited as reasons why trainees may not pursue a surgical career in OMFS. Chief among these are the length and complexity of the training programme, the impact of this on quality of life and finances, and the lack of awareness of the specialty and scope of practice[2]. Gender is another barrier in surgical specialisms, with few women entering surgical professions[3], and this is reflected by the fact that a small proportion of Maxillofacial Consultants in the UK are female[4]. That said, our specialty is evolving towards greater diversity and this percentage is projected to increase by 2024[5]. In a recent survey of Foundation Doctors[6],

just under half were found to be dissuaded from the specialty because of the need for dual qualification. Given these issues, and given that OMFS is one of the ten recognised surgical specialties in the UK, it is logical to question the need for a dental degree as a pre-requisite to entering specialty training.

Current requirements

Qualifications in medicine and dentistry, together with completion of the 2-year foundation and core surgical competencies training programmes, are currently required for entry into OMFS specialist training. The option of run-through training is available in some regions, continuing immediately after the foundation programme. Clarity and information about this process is freely available to prospective students from several sources, including careers websites (www.healthcareers.nhs.uk).

Professional identity

Research suggests there is limited awareness of the scope of OMFS amongst the public and fellow health care professionals compared with other, better-known specialities, such as otorhinolaryngology or plastic surgery[7]. This is not surprising given that there is still limited exposure to the specialty in the undergraduate curricula of medicine and dentistry degrees, and in the early years of postgraduate training. However, this may reflect our specialty's confusion with its own identity[8], a problem that is compounded by inconsistencies in the international requirements for dual qualification. A recent global analysis and review was performed that confirmed the complex status of OMFS training in different countries. This revealed that there was universal acceptance of the need to train future surgeons in both dentistry and medicine, and that irrespective of the basic qualification, residency programmes in OMFS (as distinct

from oral surgery courses) should be at least 4 years in duration[9]. Strict adherence to the identity of the specialism may appear trivial, but it cannot be discounted because it has been shown to affect recruitment, career motivation, and individual training. When there is a loss in the sense of belonging and identity within a speciality, there may be attrition in trainee numbers[10]. As such, a balance must be struck between increasing trainee uptake and maintaining our identity.

Retention of a dental qualification

OMFS has often been described as bridging the professions of dentistry and medicine. While the specialty has advanced beyond recognition from its origins in dentistry, retaining dental qualifications should be regarded in a positive light. The unique identity afforded by our training allows for an ease of conversation and shared language with both medical and dental colleagues, together with a sense of parity in the clinical relationship. Membership of both professions also grants us a very specific lens through which we view patients and approach care with a particularly broad skill set. Our understanding of, and close affiliation with, dental specialities allows us to treat diseases, injuries, and disorders affecting the head and neck with the knowledge and skill to restore a functional occlusion. Retaining dual qualification and diversity in training, and including a portfolio of skills in dental and general surgery, justifies our identity as experts in this clinical field. This has promoted a close working relationship and respect from those specialties that traditionally treat patients with disorders of the head and neck, while allowing us to provide a more holistic and generalised approach to their care. The undergraduate dental curriculum ensures that OMFS trainees have greater exposure to head, neck, and oral anatomy, as well as orofacial pathology and aspects relating to the temporomandibular joint and occlusion. By contrast, there remains minimal reference to the dentition, oral cavity, and associated specialised anatomy in medical training. Advocates of a ‘bolt-on OMFS’ model of training to a single medical qualification could see this specialist

knowledge diluted and ultimately lost.

A shared future

As a speciality, we should be promoting ourselves to as wide an audience as possible. Diversity and flexibility in OMFS training programmes should mirror the general attitude of our fellow surgical colleagues to attract as many dedicated, talented, and enthusiastic people as possible. We benefit from many excellent educators and mentors within our specialty and should leverage their skill to maximise our exposure in undergraduate and postgraduate fora.

By taking senior educational roles in universities and by providing leadership in foundation and core training programmes within deaneries and within Health Education England, we can promote the specialty. There are currently a host of opportunities within the academic foundation programme to harness the energy and drive of keen doctors to develop the clinical and academic profile of our specialty. In turn, this would help to develop and promote research into OMFS conditions. Innovative careers days with professionals from medical, dental, and nursing professions alike can stimulate the requisite energy and enthusiasm around the specialty. There are many excellent examples where OMFS units provide mentoring and support for their 'second degree' students, such as those providing trainees with regular shifts and involvement in teaching days and weekly ward-based teaching. These ideas need to be shared at a national level if we are to generate a feeling of continued support that nurtures and promotes the culture and identity required of our specialty. In line with this, graduate level entry into medicine is becoming increasingly common, and many trust, foundation, and surgical schools are adopting an increasingly strong ethos of pastoral care for these trainees.

It is entirely appropriate that we should review and address the duration of OMFS specialty training with the Specialty Advisory Committee, General Medical Council, General Dental

Council, and other relevant stakeholders. Indeed, there are certainly many possible areas in undergraduate, foundation dental, core dental, and core surgical training that may be redundant and potentially removable to help streamline training. However, the specialty must ensure that it adopts a clear strategy that promotes coordinated undergraduate and postgraduate programmes.

In the words of one who helped to establish OMFS as a specialty in the UK, 'long may the specialty continue to develop and long may we maintain our close relationship with both medicine and dentistry for this has served our patients well'[11].

Conflict of interest

The authors have no conflicts of interest to report.

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