Contribution to Commission on the Future of Surgery on Behalf of the British Association of Oral and Maxillofacial Surgeons (BAOMS)

Recruitment, retention and training in Oral and Maxillofacial Surgery (OMFS)

No contribution to a Commission on the Future of Surgery could be made without raising the significant concern around the future of surgery in general and in particular the specialty of OMFS concerning recruitment, retention and training.

Pressures specific to OMFS include:

- the financial aspects of the costs of second degree studies,
- the impact of the change from end salary to average wage pensions, and
- the new interpretation of Schedule 13 paragraph 7 of the New Contract T&Cs giving seniority only for the duration of the second degree rather than the full extent of dual training.

These monetary matters are compounded by failure of HEE and other educators to deliver on the recommendations of the PMETB Review of OMFS training 2008[i], a decade ago this year. One of the principle recommendations of the PMTEB review was the integration of the second degree into higher training in OMFS. There are effective models for this in Germany, and yet the General Medical Council (GMC) interprets EU law as preventing this.

BAOMS met with the GMC along with Sir David Edward, the judge instrumental in creation of the legalities the GMC lawyers are interpreting.

Sir David has explained verbally and in writing that they are interpreting EU law incorrectly, yet they remain unmoved.

The Review of OMFS Training was the first intensive report activity of PMETB, at some cost, during its short life. We ask for the surgical community to support our efforts to deliver on all its recommendations and to work with the British Medical Association to ensure that the New Consultant Contract is 'fit for purpose" and does not further disadvantage Oral & Maxillofacial Surgeons, either in Training or practice.

Minimally invasive surgery and robot-assisted surgery

Within OMFS some innovators are driving forward minimally invasive principles including robotic remote surgery procedures. These have yet to supplant more conventional approaches, but are gaining traction. Robotic surgery and laser resections for oropharyngeal cancer are established clinical areas for OMFS activity at present.

Imaging and virtual/augmented reality

Outside the UK, there is wide access to in-theatre imaging (C-arm CT) and the use of navigation with augmented reality and virtual reality. We anticipate this growing to support surgical practice when

working in difficult areas (orbit, skull base) and also to support digital planning for jaw moving (orthognathic) and craniofacial surgery.

Genetics and genomics
This will be a massive area of advance both for planning appropriate treatment in managing head and neck oncology (as with other cancer types). It has the potential to impact on Head & Neck cancer surgery in the same way that interventional cardiology impacted on cardiothoracic surgery.

Regenerative medicine and tissue engineering
The potential for regenerative medicine in facial reconstruction for trauma and oncology will likely reduce the additional surgical impact of donor sites. Initial experience with tissue matrices for nose and tracheal reconstruction, even simple bone templates, has been limited so far.

Transplantation
Face transplantation has been shown to be effective in relatively rare circumstances, but remains at the edge of current practice, whilst high profile and with public impact. Some work on generating replacement teeth looks interesting, but will require significant development before it can approach the current effectiveness of titanium dental implants.

3-D Printing and planning, implants and prosthetics
OMFS deformity, trauma and reconstructive surgery is beginning to adopt 3-D printing and planning technology. As the costs of this reduce, it is likely that it will revolutionise the relationship between the surgeon and the maxillofacial laboratory. It is likely that, for the time being, there will still be a need for the artistry of maxillofacial laboratory technicians to enhance the purely computer based approaches to prosthetics.

There are many areas where prosthetics (eye, nose and ear replacement) supported by bone implants produce excellent results. OMFS is well established practice in this area in partnership with their laboratory technicians.

Stem cells
These may have a role in promoting healing in the compromised patient, or generating tissue within tissue transfers but experience using stem cells with inorganic matrices on the face has not been positive so far.

Pharmacology
A major concern for OMFS, as with other surgical specialties, is the potential to lose effective antibiotic therapy as infections caused by resistant organisms increase. Dental infections continue to rise, and dentoalveolar infection is a prime source of repeat, inappropriate or incorrect antibiotic prescribing.

The most effective intervention for preventing dental decay and subsequent dental infection, the fluoridation of water supplies, remains sporadically used.

Developments that may alter the choice of surgery as the preferred therapeutic intervention, or even make surgery redundant.

It is feasible that in the longer term the genomics of cancer and tailored treatments may make the surgical management of oro-facial cancer redundant. That said, the increasing use of chemo-radiotherapy has not yet ended the need for surgery, but rather made that surgery more challenging. It seems likely that any development in this area may reduce the total surgical burden, but mean the surgery that is needed will be more difficult and more complex.

Patients and their choice of treatment in a rapidly changing health and social care system

OMFS is already impacted by the rapidly changing health and social care environment and this impact has an important lesson for other surgical and medical specialties.

NHS dentistry has moved over the years since the NHS started from being genuinely universal and free at the point of delivery, to a means tested, postcode restricted, residual package. Changes in the way NHS Dentistry is contracted has direct impact on OMFS units. The side-issue of the dental specialty of Oral Surgery, in the context of Oral and Maxillofacial care provision, has distracted strategic planners and commissioners. A substantial burden of routine and simple surgical care previously legitimately considered part of General Dental Practice is now rerouted to Hospital OMFS Departments. This has been highlighted and will be targeted as a result of the imminent publication of the "Getting It Right First Time "initiative in OMFS.

The training and role of future surgeons

The specialty of OMFS remains committed to being a substantial and productive surgical discipline, bridging between dentistry and medicine for the benefit of our patients. Being trained to be a good dentist and a good doctor remains a requirement for those who practice in our field. Surgical expertise is examined twice in Training and a wider overall clinical exposure brings benefits in terms of competence, resilience and confidence in clinical work.

Staffing and career pathways of the surgical team

There are changes planned for the provision of training in dentistry, and therefore care provision. These plans, badged as Advancing Dentistry, are in an outline stage at present. It is difficult to anticipate what the changes will look like. If Dental Core Trainees (DCTs) are removed from secondary care, this will have an immediate impact on OMFS care as this group provide first-line care within many OMFS units. More worrying would be the delayed impact on the recruitment of new OMFS surgeons as more than half OMFS manpower recruitment stems from the exposure of these young dentists to our specialty.

Exposure of core trainees and foundation trainees to OMFS is essential to the future of our specialty. We ask that the Commission recommends that all Foundation schools and all schools of Core Surgery ensure that exposure of trainees to OMFS is part of their programme. Currently, only a minority of Core Schools include exposure to OMFS in their rotations. OMFS is unique amongst the 11 surgical specialties in being left out in this way.

Experience shows that where exposure to OMFS is included, OMFS is a consistent and popular choice, resulting in many of these young doctors being so enthused by OMFS that they decide to pursue a career in our specialty.

Ethical and regulatory challenges

Surgeons in OMFS remain the only group within surgery who are exposed to two regulators – the General Medical Council and the General Dental Council. For 20 years BAOMS has striven hard for these regulators to agree a joint approach to the regulation of OMFS without success.

The reasons for lack of uptake or understanding vary but little progress has been made.

This has led to a series of cases where the GMC and GDC have differing approaches to the same complaint with for example the GDC enforcing a harsher sanction that the GMC[ii].

Support from our surgical colleagues to move the regulators to agree a Memorandum of Understanding for OMFS surgeons, and aim for uptake of the recommendations of the Rubin Report about OMFS Training is absolutely essential and would be a great advance and relief.

Patient safety

There is concern in the specialty about the breaking up of OMFS units (as happened when the OMFS Cancer Services were moved from Barts and The London to University College Hospital). Maintaining a focus of airway management skills and combining trauma and reconstruction creates the best patient care. Working with other specialties in units with combined acute and elective operating give the best focus of manpower and skills, any wholesale changes should take into consideration the impact on the specialty of OMFS.

Clinical outcomes

Recently the removal of HQIP funding from the national Head and Neck Audit (HANA) had the potential to destroy an important clinical outcome audit. This has been rescued by funding from the charity 'Saving Faces' but BAOMS remains concerned about the lack of funding available to support the measurement of clinical outcomes across surgery in general and in OMFS in particular.

The model where surgeons, through their specialty association, pay for their own outcome measure is simply not sustainable.

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[i] PMETB Review of Training in OMFS 2008 (Post Graduate Medical Education and Training Board). https://www.baoms.org.uk/_userfiles/pages/files/Professionals/Education%20and%20Training/2008%20PMETB%20Report%20into%20Training%20OMFS.pdf (Accessed 18 Feb 2018)

[ii] Review of General Dental Council and General Medical Council "fitness to practise" hearings related to maxillofacial surgery
R. Taylor, M.H. Ali, T.E. Howe, I. Varley
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