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Oral and maxillofacial surgery – future uncertain?

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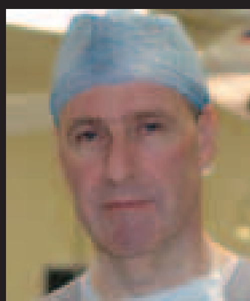

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Oral and maxillofacial surgery (OMFS) occupies the confluence of the two great professions of medicine and dentistry. It has developed as a consequence of cross-fertilisation of ideas between surgery and dentistry, from which patients have benefited. While the last decade witnessed OMFS becoming firmly established as one of the nine SAC-recognised surgical specialties, only in the last couple of years has the dental specialty of oral surgery became disarticulated from OMFS.

Many of us believe that the establishment of a separate SAC represents a retrograde step. It should be remembered that most dento-alveolar surgery performed in the UK is provided in hospital departments of OMFS, by teams comprising both OMF surgeons and oral surgeons mainly working in the SAS grades. The majority of oral surgery specialists remain members of BAOMS and work closely on a daily basis with OMFS colleagues, providing an invaluable service.

The recent Postgraduate Medical Education and Training Board (PMETB) review of OMFS confirmed the quality and range of OMFS delivered in the UK and affirmed the need for surgeons to acquire registrable qualifications in both medicine and dentistry.[1] However, it also recommended where there is overlap in training, competencies acquired should be credited in order to streamline training and permit movement between the two specialties. PMETB also recommended that the Department of Health undertake a review of oral surgery and BAOMS wishes to engage fully with the proposed review.

Some have suggested that OMF surgeons have no interest in dento-alveolar surgery and wish to dissociate themselves from dentistry. The recent change in legislation, which removed the necessity for consultants in OMFS to be dentally registered, is miscited as evidence of this. Nothing could be further from the truth. Removing the requirement for dual registration was the only mechanism acceptable to the General Dental Council (GDC) to prevent OMF surgeons being required to revalidate twice. Indeed BAOMS would have preferred a solution enabling OMF surgeons to retain both GDC and General Medical Council registration, with only one regulator assuming responsibility for revalidation.

BAOMS council is of the opinion that the close-working relationship that exists between OMFS and dentistry should continue in order that patients benefit from well-balanced teams and streamlined care pathways. BAOMS supports high-quality training of specialist oral surgeons to complement the work of OMF surgeons but only for those core competencies specified by the GDC. There is no place, nor justification based upon clinical need, in a modern health-care system for singly dentally qualified specialists performing surgical procedures such as complex trauma, facial deformity or salivary gland surgery, as proposed by a small minority of oral surgeons. We hope that the SAC in oral surgery and GDC will rapidly conclude what has been a lengthy process of agreeing the curriculum for oral surgery so that oral surgery training programmes can be established that meet required standards.

Over the past 50 years we have witnessed profound improvements in the evolution of maxillofacial surgical techniques. OMF surgeons have expanded their training and expertise to encompass, among other things, head and neck and skin malignancy, microvascular reconstruction, complex congenital and acquired craniofacial deformity, and most recently the rapidly developing field of cosmetic facial surgery. Long may the specialty continue to develop and long may we maintain our close relationship with both medicine and dentistry through the College and its Faculty of Dental Surgery, for this has served our patients well.

Reference

1. The Postgraduate Medical Education and Training Board. *PMETB report on training in Oral and Maxillofacial Surgery (OMFS)*. London: PMETB; 2007 (http://www.pmetb.org.uk/index.php?id=817).