Title: “Where are they now?” A Survey of Former Oral Surgery Trainees

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Abstract

Introduction

This study aimed to gather demographic data from the oral surgery workforce who have experienced a formal training pathway, their current roles, commitments, competencies and how they believe oral surgery training could be improved.

Methods

A 22-question online survey was developed and distributed to 70 former oral surgery trainees. Trainee details were retrospectively obtained using the British Association of Oral Surgeons (BAOS) Consultants and Senior Trainers (CAST) group mailing list and the oral surgery trainee mailing list and potential participants were invited via email.

Results

Six participants reported not having had formal training and were excluded, resulting in a 47% response rate. The majority (78%) of former oral surgery trainees appear to spend most of their working week in hospital practice, with 63% in oral surgery consultant or honorary consultant positions. Participants reported a mean average of 5 WTE oral surgery sessions working for the NHS and 1 WTE private session. Oral surgeons have a broad remit of roles and responsibilities including teaching and training, policy making, research, leadership and management. Respondents suggested improvements for any future oral surgery specialty curriculum, including more leadership and management training to ensure trainees are well prepared for senior posts.

Conclusion

Overall, this survey demonstrates the broad and diverse skills of the oral surgery workforce. The majority of former oral surgery trainees currently hold consultant level positions and are mainly based in hospital practice. This study also demonstrated that a large proportion of the oral surgery workforce commitment is to the public sector.

Clinical Relevance

Rationale for study: Accurate workforce data is not currently available for those who have experienced a formal oral surgery training pathway.

Principal findings: Oral surgeons have a broad remit of roles and responsibilities. The majority of former oral surgery trainees appear to spend most of their working week in hospital practice, within senior positions. Suggested improvements for any future curriculum included more leadership and management training.

Practical implications: It may be prudent that results from this survey should be taken into consideration alongside workforce planning and curriculum development projects, to ensure there are adequately trained numbers of oral surgeons.

Main text:

Introduction

Specialty training in oral surgery is a 3-year pathway leading to the Certificate of Completion of Specialty Training (CCST).[1] There are currently 60 training posts in the UK with competitive entry via national recruitment. The Royal College of Surgeons of England Guidance have approved personal specifications for NHS or honorary consultants in oral surgery [2] and while not formally approved by COPDEND, post-CCST training is described as a further 24 month period in a Specialty Advisory Committee (SAC) approved programme, covering a range of 'extended competencies'.[3] Prior to the introduction of the current oral surgery programme in 2009, the specialty of surgical dentistry and the Academic Advisory Committee for Oral and Maxillofacial Surgery (AACOMS) training programmes existed. As a European Union (EU) recognised specialty, there are now 11 potential routes to gain entry onto the oral surgery specialist list.[4,5]

Following training, oral surgery specialists may work in and across many different roles including as oral surgery consultants, specialty dentists/ doctors and associate specialists, or within primary care and community settings, but as Fullarton *et al.* reported, data for this has been difficult to obtain.[4] We surveyed 70 former oral surgery trainees, to gather demographic data from the current oral surgery workforce who had experienced a formal training pathway, their current roles, commitments, competencies and how they believe oral surgery training could be improved.

Methods

A 22-question online survey using Surveygizmo® (Boulder, Colorado, USA) was developed and distributed to 70 former oral surgery trainees. Trainee details were retrospectively obtained using the British Association of Oral Surgeons (BAOS) Consultants and Senior Trainers (CAST) group mailing list and the oral surgery trainee mailing list. Potential participants were invited to the study via email link. In accordance with General Data Protection Regulation (GDPR) all respondents were contacted prior to the survey to ask if they were happy to take part, including detail on the purpose of the survey and what the data would be used for. The survey consisted of open free text, binomial and variable scale responses. Participants were not offered any incentive and all results were anonymised through the Surveygizmo® platform. All survey questions were compulsory and only completed questionnaires were analysed. Data collection took place between 09th September 2018 and 17th October 2018.

Results

A total of 39 people responded, however six participants reported not having had formal training and were therefore excluded, resulting in a 47% response rate (33 people). Oral surgery specialists, from across the UK, replied to the survey, with only 6% from other regions outside of the UK (**Fig.1**). The majority (43%) had been registered as a specialist for between two and five years, with 10% of respondents being registered for

one year or less and the remainder for six years or more. Proportionally, 78% of former oral surgery trainees appear to spend most of their working week in hospital practice (either district general, secondary or tertiary care), with only 13% based mainly in primary care and even less (5%) in the community dental service (**Fig.2**).

< Figure 1 here >

< Figure 2 here >

Over two-thirds (n= 24) had been trained in a recent formal pathway i.e. Specialist Registrar (StR), Academic Clinical Fellowship (ACF) or Academic Clinical Lectureship (ACL) UK training post. Of these 30% (n=10) were academic trainees. A further 18% (n=6) were on the ACCOMS training programme. Three others described their training as formal but via other routes, such as training in other recognised countries e.g. Germany, or had completed a previous specialty registrar (SpR) post in surgical dentistry.

The majority (63%) of respondents were now in oral surgery consultant or honorary consultant positions, with 15% reporting clinical, senior clinical lecturer and reader academic posts and 9% holding chairs as a professor. Only 12% reported being in specialty doctor/dentist roles. Twenty-four percent had a full or part-time role in primary care and 6% worked for the community dental services (**Fig.3**). It was possible for each participant to report more than one job description and so these numbers have been represented with a heat map to demonstrate the correlation between posts in **Fig.4**. There

appeared to be a strong correlation between those in academic roles holding honorary consultant positions and a moderate correlation between both private and NHS primary care. Private sessions in primary care were reported by 33% of oral surgeons regardless of job description, but a large proportion (75%) of oral surgeons reported working national health service (NHS) sessions. Participants reported a mean average of 5 WTE oral surgery sessions working for the NHS and 1 WTE private oral surgery treatment session.

< Figure 3 here >

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In addition to this, most participants reported a broad range of responsibilities in their jobs such as teaching (82%) and training (73%), policy making (27%), research (39%), leadership (61%) and management (75%) (**Fig.5**). A mean average of 4 working days was reported by all oral surgeons. Weekly mean averages of 3.5 whole time equivalent (WTE) operating sessions, 3 WTE sessions teaching and training, 1 WTE sessions on research, 1 WTE sessions for leadership and 1.5 WTE sessions on administration were reported. Only 3% were involved in on call rotations at any level.

< Figure 5 here >

All participants reported sitting one or more professional examinations including the Membership in Oral Surgery (MOral Surg) (63%), Fellowship in Dental Surgery (FDS)

(30%), and Intercollegiate Specialty Fellowship Examination in Oral Surgery (ISFE) (21%). Only two people who sat the ISFE had also taken the MOral Surg, but five people had taken both the ISFE and FDS.

When asked about extended (post-CCST) competencies training, the most commonly reported area (55%) was in ‘advanced implantology and bone augmentation for oral rehabilitation’. All other responses are shown in **Table 1** with a third or less reporting training in most of the extended competencies. Fifty-eight percent agreed or strongly agreed that they were ready to take up a consultant post immediately following their training. In the open free-text section asking, “How do you feel your oral surgery training could have been improved?”, many respondents asked for more structured training leading to a consultant role, with better “leadership and management training” as a recurrent theme. Other comments suggested a more structured, extended run through training to include ISFE as an exit examination and a call for more post-CCST positions in general.

< Table 1 here >

Discussion

This survey captures the current position of former oral surgery trainees, all of whom had experienced a recognised training pathway. Although previous surveys have examined the scope of practice of UK oral surgeons, none have focused specifically on those who

had been through formal training.[6] The response rate was above average and was representative of regions across the UK. Most former trainees (78%) appear to have a role in hospital practice and almost two-thirds (63%) occupy senior academic or clinical consultant roles within these settings. This is reassuring as NHS Medical Education England's Time for Training review concluded that it was 'imperative' that the NHS develop a 'consultant-delivered service' in each recognised specialty and that individuals who are 'clinically responsible for service delivery should be employed in substantive posts under the consultant contract'.[7,8]

However, only 58% agreed or strongly agreed that they were ready to take up a consultant post immediately following their training, suggesting the opportunities to acquire the necessary competencies for a senior level appointment in oral surgery need to improve. In one study of 840 new medical consultants, they considered themselves better prepared for clinical practice than in generic competencies, with no significant differences between specialties.[9] Multiple other papers suggest that specialty trainees in medicine felt underprepared for the non-clinical responsibilities associated with being a consultant, including communication with the interprofessional healthcare team and wider organisations; leadership; teaching and supervision of others; and management responsibilities.[10,11,12] In this survey, 28% said they had no extended competencies and respondents recommended more training in leadership and management, with only 30% stating they had any formal training in this area. The NHS has said that it needs high quality leaders 'at every level and in every area to ensure that it is able to deliver high quality compassionate care' for patients and understanding NHS management structure

is essential for delivering an efficient and effective service. This is further reflected by previous government and Health Education England mandate to improve leadership training within the healthcare workforce.[13] While traditionally these skills were expected to be developed within consultant posts it is imperative that a good grounding is established prior to taking up the role during specialty training.[14] This is particularly prudent given the emphasis placed on encouraging leadership qualities in other medical specialties,[15] as well as the increasing willingness of trainees to engage with leadership as part of their own personal development.[16] The current evidence relating to preparedness for dental specialty status and equally for consultant posts is negligible.

It was clear in this survey that oral surgeons provide a range of roles and responsibilities in addition to their clinical practice, the most common being teaching, training, leadership, clinical governance and management, as well as some reporting contributions to policy making and research. The mean average number of reported WTE oral surgery sessions for the NHS was 5 compared to only 1 in the private sector demonstrating a large proportion of oral surgery commitment to the public sector. Unfortunately, we did not collect information on how many university sessions were worked in addition to NHS and private sessions. Overall, this survey demonstrates the broad and diverse skills of the oral surgery workforce.

Former oral surgery trainees called for more post-CCST opportunities and a run through training leading to ISFE as an exit examination. While the GDC plan to revise dental specialty curricula,[17] a validated post-CCST fellowship model, such as those already

offered in quality improvement or research for example, may offer one solution in the meantime. Less than 30% of participants reported having been trained in the 'extended clinical competencies' as listed in **Table 1**, suggesting these may require revision.[2,3] Such low responses may also highlight the reduced number of trainees obtaining post-CCST experience following their 3-year specialty training in oral surgery, as it appeared to be generally the same people obtaining multiple extended competencies training rather than multiple trainees acquiring only one or two competencies. This also highlights inconsistencies in training delivery and variation both within and between deaneries and training centres. These figures were lower than that reported previously by Patel and Ormondroyd (2014), when they asked 40 oral surgery trainees about their exposure to various 'extended competencies' to the post-CCST curriculum.[18] This may be explained by the fact that our question was phrased specifically around achieved training competencies, rather than exposure. In this study, over half (55%) stated they had training in 'advanced implantology and bone augmentation for oral rehabilitation', which was similar to the findings by Patel and Ormondroyd,[18] suggesting that perhaps this competency should remain on any revised curriculum.

One limitation of our survey was that it did not explore the extent of training and education in each competency, in order to understand the depth of extended training experience. Medical Education England's Review of Oral Surgery Services and Training endorsed 'the creation of appropriate numbers of training programmes and posts' in oral surgery, for the 'education of the next generation of academics and trainers' in the specialty. The results of this survey suggest improvements in the current training

curriculum are needed, to ensure oral surgeons are well prepared for these roles.[7] While the response rate appeared low at 47%, 39 responses for a small specialty such as oral surgery is relatively informative. Furthermore, it may be prudent that results from surveys such as these should be taken into consideration alongside workforce development projects and health needs assessments, to ensure there are adequately trained numbers of oral surgeons available in parallel with the commissioning of future oral surgery services.

Conclusion

The majority of former oral surgery trainees currently hold senior academic and consultant level positions and are based in hospital practice. This study demonstrated that a large proportion the oral surgery workforce commitment is to the public sector. Oral surgeons have a broad remit of roles and responsibilities in addition to their clinical practice, including teaching, training, policy making, research and governance. Participants suggested improvements which will be useful for designing any future oral surgery specialty curriculum, including more leadership and management training alongside achievable extended post-CCST competencies where there is capacity and a need for training in those areas.

Figure Legends

Figure 1. Working location of former oral surgery trainees

Figure 2. Where former oral surgery trainees spend most of their working week

Figure 3. Job title(s) that best describe the role of oral surgery trainees following training

Figure 4. A heatmap demonstrating correlation between reported job descriptions

Figure 5. Additional job roles and responsibilities reported by former oral surgery trainees

Conflicts of interest

There are no conflicts of interest to declare.

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