Editorial

Fellowships post maxillofacial residency- Is it necessary?

INTRODUCTION

Oral and maxillofacial surgery (OMFS) has always been a controversial branch in terms of its scope and training because of the different curriculum with the mandate of dual degree in various countries. Moreover, vast scope of cranial and maxillofacial region makes it a valuable branch, but lack of strict guidelines of the work and thin demarcation from plastic and otolaryngology adds to the debate. Although maxillofacial was initially started as a branch of dentistry in India, the complexity of craniofacial region makes it essential to incorporate extensive exposure of medical and other surgical specialities including plastic, neurology, otolaryngology ophthalmic, and general surgeries in the training.

It is far beyond fascinating to learn that initially the maxillofacial surgery was included in medical fraternity probably because there was nonexistence of formal dental education. Nonetheless, when schools in dentistry started in the late 1800s, almost all the oral and maxillofacial surgeons understood the significance of dentistry in the treatment, and started to obtain a formal education in dentistry. Thus, the majority of the early oral and maxillofacial surgeons were all dually qualified. Hence, the most controversial question whether dental or medical or dual degree should be acquired came into existence for the surgeons opting for the maxillofacial speciality.[1]

As per the European directive 2001/19/EC, the oral surgery specialty has been separated from the oromaxillofacial surgery (OMS) specialty, which requires 5 years in medically based curriculum (as in France, Spain, Austria, and Italy) and 4 years in a dual-degree syllabus (as in Germany, Switzerland, Belgium, United Kingdom, Ireland, and Finland).“Oromaxillofacial surgery and stomatology” in Europe is a medical specialty and is governed by the European Union of Medical Specialists. Furthermore, each eligible candidate for the Fellow of the European Board of Oro-Maxillo-Facial Surgery and Stomatology must be a recognized maxillofacial surgeon practicing in one of the European countries for at least 2 years and holding a medical degree (dual degrees are mandatory in some countries, whereas a dental degree is optional in others).[2,3]

In USA, the dual degree is not essential and maxillofacial residency can be opted after Doctor of Dental Surgery (DDS). There are two ways via which certification by the American Board of oral and maxillofacial surgery (ABOMS) can be obtained: one way is by a 4-year certificate program, which includes 1 year of medical training on off-service rotations and 4–6 months of anesthesia; and a 6-year training program that integrates completion of a medical degree, 4–6 months of anesthesia, and 1–2 years of general surgery residency. The number of months spent on the OMFS service is typically 30–36 months in either program. Advanced training fellowships are available in head and neck oncologic surgery, reconstructive microvascular surgery, pediatric craniofacial surgery, and cosmetic surgery.

The other way is applicants should be graduates from either predoctoral dental programs in the USA accredited by the Commission on Dental Accreditation (CODA); or predoctoral dental programs in Canada accredited by the Commission on Dental Accreditation of Canada; or International Dental Schools that provide equivalent educational background and standing as determined by the maxillofacial program in Northern America.[4]

Since 1970, the mandate of dual degree is abolished in USA but to suffice for the need of extensive medical and surgical trainings, the duration of OMS residency has been increased from 4 to 6 years.

In other Asian countries OMS is governed by dental authorities with the duration of training from 4 to 6 years after bachelors in dentistry. Likewise, in Nordic countries maxillofacial surgery is a dental speciality with 6 years of training in the field post bachelors.

In India, maxillofacial is primarily a dental specialty. Post bachelors in dental education, maxillofacial residency can be chosen without any mandate requirement of medicine or Observership. Maxillofacial residency is a 3 year program

with first year for medicine and surgery rotations followed by 2 years of exclusive maxillofacial work along with Observership in subspecialties like oral oncology and cleft surgeries. The maxillofacial surgery has various subspecialities including oral oncology and reconstruction, facial esthetics, implantology, maxillofacial trauma, orthognathic surgeries, and cleft surgeries. The boundless scope of maxillofacial surgery cannot be countered to the present box of teachings and curriculum despite high efforts by the teachers and the system. Despite getting degrees from well-established colleges, the need of fellowships cannot be ignored to incorporate the full scope of maxillofacial surgery.

Moreover the duration of training in OMS residency is less when compared to the standards of Europe, America, and other Asian countries which further necessitates the need of additional training in OMS residency in India.

PROS AND CONS OF FELLOWSHIPS

The explanations behind seeking after extra fellowships preparing incorporate accomplishing clinical ability, expanding certainty, enrollment, notoriety and gaining particular abilities alongside the securing of attractive abilities and the accomplishment of explicit profession objectives. According to the staff's point of view, fellowship programms have been proposed as an answer for the issue of additonal clinical inclusion and have been noted to furnish scholastic and clinical advantages by educating more junior students and getting assistance in exploraing and improvement in volume and nature of clinical administrations.

Moreover, fellows free up the time of formal consultants by sharing the duties and responsibilities leading to more coherent atmosphere in the system. Presence of good fellows can increase the clinical productivity of the system, fellows are also involved in teaching the junior staffs thus elevating the pressure of additional responsibilities from senior staffs. Research and publications have also improved in the department with fellows due to division of work.[5]

The obvious pros are enhancement of skills, confidence in surgical precision, and fulfilment of the desire of excelling in the sub-speciality which might not be possible by formal training alone. Post fellowship the chances of recruitment increases manifold primarily because of enhancement in surgical skills and confidence of the surgeon. It makes surgeon additionally qualified and gain advantage against the peers who did not do fellowships in terms of knowledge, skills, and learning.

The fellow gains the mentor who is at higher level in the field and can guide him or her to tackle the adversities which he himself had faced in the establishment of the career. Thus sharing experiences can reduce the chances of the initial mistakes in the starting of one's career.

Fellowship is not a formal training program and thus the relationship between the mentor and the student can not only enhance the fellow's self-belief but also develops a sense of security in attaining one's career goal with the help of the mentor. The presence of mentor makes the surgeon to work skilfully relying on mentors' experience.

The cons is additional duration which might be detrimental to the economic condition of the student who is already burdened by huge loan taken during the residency. Moreover, the chances of loosing of skills of other subspecialities while concentrating only on the chosen field during the fellowship is there. The additional cost and burden might pose an excess burden on the student's mental and physical health. In addition to this going back to begin the practice post fellowship when your peers are already established can be troublesome for some surgeons. Also, the fellows are additional trainees; and in a center with limited cases may pose a danger in learning of junior staffs which may affect the training curriculum of additional degrees running in the institution.

Factors to be considered while choosing the sub-speciality:

The important factor in choosing the sub-speciality for fellowship is the genuine interest in the subject. The grandeur of surgery, aura of precision, adrenaline high of emergency, and surgeon's panache may sometimes allure the residents to opt for the filed, which they may later could not cope after experiencing the ground reality and hard work. Thus, it is advisable for the trainee to go for Observership for few months in the respective departments to gaze his or her real interest. This will save time and energy of the trainee and the mentor as drop outs will be reduced.

The trainee should be in a moldable state and thus receptive toward the working philosophy of the center.

The factors responsible for trainee's satisfaction include the proper distribution of floor work and operation theatre (OT) schedules. The fellowship program is a structured program where all nuances of sub-specialities should be taught including surgical skills, patient's management, marketing, ground work management, communication, and hospital administration. Skilled surgeons who are unable to get patients and skilled managers who are not able to operate have no value. Thus fellowship program should aim for the overall development of the trainee which should groom them into a competent surgeon.

Quality enhancements can be made in addresses, fabulous adjusts, and active abilities labs to further develop learner fulfilment and generally instruction.

Another important factor which should be kept in mind are the total number and types of cases in the center. The total number of cases are extremely important as it increases the experience and exposure of the trainees. This leads to surgical independence and increase of confidence. The main aim of fellowship programs is to deliver competent surgeons which can only be given by providing surgical independence and skills transfer by the faculties possible only in high volume centers.

The other variable for selection of fellowship program should be the reputation, skills, experience, and standing of mentor and the center. This is significant, and it requires a drawn out obligation to staffs advancement and asset allotment by centers. In general program honor, fame, and student fulfilment ought to improve by giving deliberate attention in keeping the long-term good staffs by engaging, and motivating them both professionally and financially. Staffs standings are significant in terms of knowledge, expertize, character, and values.[6]

The fellows should look for basic stipend so that basic needs can be fulfilled making them less vulnerable to excess financial burden.

The last but not the least factor while choosing the fellowship center should be similarities between the ideology of the mentor and the fellow. Similar values and ideologies can lead to successful relationship between the mentor and the mentees which may lead to improvement in overall relationship and thus improvement in satisfaction of the course.

Need for globalization of OMS training:

As the cross-border interaction is extremely high these days, there is need for standardization of OMF training across the world. There is a vast variation of training, safety, quality, and standards among surgeons. Thus, it is high time that the training should be incorporated in such a way that skilled and almost equally competent surgeons are produced in terms of skills, knowledge, and patient's safety. The need to assure competence is mandatory worldwide for better patients' safety and the growth of the specialty.

Use of simulators and models is a good way to enhance the skills of our trainees without jeopardizing the patients.

This can only be brought by the use of information technology, tele education, and exchange of students across the world's best center. In the last 3 years, there is huge upsurge in tele education due to restrictions in pandemic. The tele education is one of the ways via which exchange of knowledge and refreshment of techniques can be done without much hassle.

However, this does not suffice the need of in-person learning from experts which is highly essential owing to the sensitivity of lives of the patients where minuscule mistake can prove to be fatal.

The value of incorporating accreditation from a globally recognized fraternity for hospitals and surgeons should not be underestimated. There are various confirmations demonstrating that accreditation brings significant improvement in patients' treatment and care, and our specialty should accept this open handedly. In fact, certain protocols should be made and only accredited institutes should be allowed to recruit fellows. It can either be nationally governed by the fraternity authorities or government should intervene in the system.

Globally standardized schooling and education, principles based program certification, standardized board/university assessments and association in medical clinic authorization, and other quality and safety drives will generally be the basic to the eventual fate of the strength; in any case, we should be on top of things with regard to utilizing innovation to further develop OMS preparing, ability appraisal, and patient consideration. Technology will surely alter the manner by which we train and evaluate our associates, and how persistent consideration is given. Remaining on top of things will require a cooperative global exertion. Luckily, the specialty has a functioning global body – the IAOMS – which can work as the "center of the wheel"' for every one of the drives referenced previously.[7]

In India, integrated programs of OMFS including additional exposure to medicine should be formed. This will up level the training for the benefits of both surgeons and patients.

CONCLUSION

OMFS has a vast scope of practice. OMFS can be practiced either in office set up including implantology, minor oral surgeries, and office base esthetic practices which obviously requires less time for training and can yield substantial returns in terms of finances and early reputation. However, if a surgeon wants to develop a full-fledged hospital based on maxillofacial practice additional training in the fellowships becomes mandatory. The road is certainly hard and difficult due to high competition with peers and other speciality surgeons owing to thin line of demarcation in the work.

We need both office bases and hospital based maxillofacial surgeons for the development of the filed. None of them is superior to each other. The only difference lies in the approach, interest, and choice of work.

The choice of fellowship is a crucial decision and should be taken cautiously after considering one's interest, circumstances, desires, and career goals. Strong mentor, intellectual provocation, and surgical independence are the most deciding factors for the trainees to choose their center and the sub-specialty. With respect to mentors, other than trainees intelligence and skills, receptivity and desire to pursue the respective field are the most important in the selection.

Dental and medical authorities should recognize the fellowship as additional degree/diploma or training, and special collaborations should be done from overseas universities for validation of fellowships in India. This will benefit the students planning to go abroad for higher studies.

With the increase in awareness of OMFS in the world, the collaboration, cooperation, and exchange of ideas between the various centers should increase the overall patient care.

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