Task Group for Orthodontics Report

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Abstract. *The UK Specialist Review Group of the General Dental Council's Education Committee has been charged with taking forward the recommendations in the Chief Dental Officer's report 'UK Specialist Dental Training'. The Specialist Review Group has, in turn, established a number of specialty task groups. This report is from the Task Group for Orthodontics. It was submitted in May 1996.*

Introduction to UK Task Group Report for Orthodontics

We welcome publication of our report. Publication has inevitably been delayed whilst the matters raised were being debated by the various committees of the United Kingdom General Dental Council (GDC) the Department of Health (DoH) and European Commission in Brussels. Now that the decisions in principle have been taken by the GDC, it is only right and proper that the specialty should have access to the full text of the report. We would also like to take the opportunity to describe the setting in which we carried out our deliberations and produced our report.

The Task Group was set up by the GDC without any written terms of reference. We therefore had to formulate our own terms of reference according to verbal comments received and our own perceptions. For example, we were informed by the president of the GDC that we should start with a blank sheet of paper and be imaginative as to what the specialty would really like for the future. It was also suggested that advice on transitional arrangements would be welcomed by the Specialist Review Group of the GDC. From the former Chief Dental Officer, we were repeatedly informed that only one Certificate of Completion of Specialist Training (CCST) would be possible in orthodontics as it is an established specialty within the European Union (EU) and that any further training post-CCST was quite simply not possible as the completion of training is precisely what it means. The only other guiding principle we followed came from the Calman report on specialist medical training which stated there should be no reduction in training standards arising from any reform or shortening of training.

The report was produced over an intense period of approximately six months during which several meetings were held in London and some six drafts prepared. Every member read hundreds of pages of documents and spent hours in communication on the telephone. Clarification was sought on issues from others outside the Task Group where appropriate. Discussions within the Task Group were vigorous at times but, by the time the final draft was produced, the report received the full and enthusiastic support of every single member. At no time was the Task Group distracted by sectional interests from within the specialty.

The report was intended to make recommendations for the UK training of orthodontists in the future. It was never intended to describe the present training pathways which are geared to the present distribution of specialist skills in the UK. If we may express regret, it is that both the specialty and the GDC seem to have been concerned by the present rather than preparing for the future. In this report, the Task Group failed to persuade the authorities and even some of its own specialty.

The GDC's decision that the CCST in orthodontics will be awarded after three years of specialty training with the possibility of two further years of training for a small number of orthodontists preparing for careers in the hospital service or academia is at odds with the recommendations in the report, and that, with the passage of time, may well have a detrimental effect on the training of specialist orthodontists in this country,

We do not wish to make further comment at this time, as we would prefer readers to draw their own conclusions.

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Introduction

1. The Specialist Review Group of the General Dental Council's Education Committee has been charged with taking forward the recommendations in the Chief Dental Officer's report, 'UK Specialist Dental Training'. The Specialist Review Group has, in turn, established a number of task groups, this report being from the Task Group for Orthodontics.

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2. This report represents the unanimous view of the Task Group which is composed of two general dental practitioners, two orthodontic practitioners, one consultant orthodontist and one professor of child dental health. The professor, both orthodontic practitioners and the consultant orthodontist are actively involved in orthodontic postgraduate training.

3. The Task Group believes the recommendations made in this report to be based on careful analysis and should not be read in isolation from the full text of the report. It was therefore decided neither to precede the report with a summary nor to conclude it with a list of recommendations.

4. Orthodontics is a diverse and sought after specialty. Recruitment is highly competitive and, to our knowledge, virtually all those who complete their training embark on a lifetime of specialty practice. Orthodontics is also a highly cohesive specialty with almost universal membership of the British Orthodontic Society (some 440 GDPs with an interest in orthodontics are also members). Over 80 per cent of UK orthodontists attend the annual four day British Orthodontic Conference, which also includes scientific sessions for orthodontic nurses and technicians. The last two conferences were attended by almost 1000 delegates, well over the total number orthodontists and trainees in the UK.

5. Historically, specialist training in orthodontics in the UK has been carried out in dental schools and district general hospitals and, until recently, has been directed towards a career pathway leading to appointment as consultant orthodontist in the hospital service. In recent years, many practitioners who have undergone specialty training and have successfully obtained a university degree or royal college diploma have chosen to enter so called 'high street' specialist practice or the community dental service rather than continue formal training for a career in the hospital service. Orthodontics is therefore unusual as it is firmly established as a specialty in hospital, practice, and clinic locations.

6. The hitherto unplanned development of specialist practice in the primary care setting needs to be formalised in the light of the GDC's decision to establish specialist lists. This will require recognition of the role played by specialists currently in practice and the establishment of appropriate training pathways for the future. It is therefore essential that any revised system is flexible enough to provide appropriate training for the specialist practitioner, the community orthodontist, the hospital consultant orthodontist and the university teacher of orthodontics.

7. Under European law[1], member states are obliged to have reciprocal arrangements to accommodate doctors and dentists whether generalists or specialists. EC Dental Directives 78/686/EEC and 78/687/EEC indicate that specialists must hold a Certificate of Completion of Specialist Training (CCST) obtained after a minimum of 3 years of recognised specialty training. It is noteworthy that a number of countries that have declared orthodontics as a specialty have opted for periods of training longer than the minimum of 3 years. There is a trend for countries with 3-year programmes to revise and improve their training.

[1] The provisions of the EC Directives have been extended to apply to the countries in the European Economic Area (the EEA includes the EU, Norway, Iceland and Liechtenstein). This report will therefore refer to the EEA as appropriate.

8. The Task Group is very well aware of expectations from various bodies and interest groups. Whilst we have read many documents, sought opinion from a variety of sources including all dental school orthodontic departments, and debated for many hours, we have kept to the task of making educational and training recommendations for the benefit of future dentists, specialists and, most importantly, the public in the United Kingdom for the next few decades.

General Professional Training

9. The Task Group supports the concept of 2 years' General Professional Training (GPT) so that all dentists may gain experience of general practice in primary care prior to embarking on a career as a specialist. It is not within the remit of this Task Group to comment on this aspect of training, other than to note that some components of specialty training are expected to begin during this period.

10. In the anticipation that part of GPT will be modular in nature, the integration of basic science with clinical science for those entering specialty training would be appropriate. It is envisaged that any orthodontic module within GPT would concentrate on normal and abnormal dentofacial development, recognition of abnormality, and, where appropriate, timing and choice of referral for specialist advice and treatment. There could perhaps be limited practical work on an observer or assistant basis. Some of this experience could be in approved specialist practice. The Task Group does not believe the orthodontic module should be obligatory for those wishing to pursue a career in orthodontics but its availability may trigger an interest and help career decisions. In many ways, this module would be more important for those with ambitions in other specialities, or general practice.

11. Once GPT of this form is firmly established, the minimum entry requirements for those entering specialist training should be successful completion of GPT, identified by the award of an appropriate qualification. Until then, the minimum entry requirement will continue to be the primary FDS examination. However, in view of the current level of competition for places for orthodontic specialty training, it is likely that most candidates will have qualifications and experience considerably beyond that of the present one year VT and the 2 years of GPT when this comes into effect. Anecdotally, it can be reported that for every M.Orth. training place, there are approximately 10 applicants, the majority of whom have a full fellowship qualification.

Specialist Training

12. This section of the report deals with those aspects which the Task Group has found to be the most controversial. It is therefore appropriate to review the background in order to highlight the areas of primary concern.

Background

13. In November 1989, the General Dental Council (GDC) invited interested parties to submit their views on

distinctive titles and lists and, more specifically, on '*the level of education (including formal qualifications) and training necessary to qualify for use of a distinctive title*'.

14. One of the many submissions to the GDC was a report in April 1990, 'Specialist Registration in Orthodontics', produced jointly by the national orthodontic organisations representing the interests of university teachers, specialist practitioners, community orthodontists and consultant orthodontists (this was prior to the formation of the unified British Orthodontic Society). This report made wide ranging recommendations, many of which were adopted in subsequent GDC consultation papers.

15. In May 1991, the GDC published a 'Consultation Paper on Introduction of Specialist Titles and a Specialist List'. This document determined that the term 'distinctive title' would be replaced by 'specialist title', and acknowledged the need to recognize orthodontics and oral surgery as specialties. This document also pointed out in paragraph 8 that '*the system under discussion relates to dental practice outwith the hospital service. Dentists who wish to attain Consultant status undertake higher training programmes under the aegis of the Joint Committee for Higher Training in Dentistry*[2] *and on successful completion of those programmes are accredited by one of the Royal Surgical Colleges. However, most dental treatment in the UK is undertaken outwith the hospital service and the purpose of this paper is to describe a possible framework for a regulated system of specialisation separate from the higher training system*'.

16. It is in this context that this document also states in paragraph 18 that '*the diploma of Member in Orthodontics (M.Orth.) awarded by the three UK Royal Surgical Colleges following three years' approved study and experience in Orthodontics and satisfactory examination performance provides one suitable model.*' This also complies with the minimum EEA requirements.

17. Following a further round of consultation, the GDC approved 'Revised Proposals for the Introduction of Specialist Titles and Specialist Lists' in November 1992. Again, this document endorsed the view that the 3-year M.Orth. diploma was '*generally accepted as a model for specialist qualifications which provide evidence of three years' approved study and training*'.

18. What both GDC and other reports from the early 1990s have in common is that they define the minimal requirements for inclusion on a specialist list. Indeed, in the case of orthodontics, the 3-year pathway of specialist training up to M.Orth. has been recognized by the GDC as sufficient to confer a status of specialist to those who wish to practise in other EEA countries. However, all the training pathways described above are based on the premise that those specialists who wish to pursue careers in the hospital service as consultant orthodontists would be able to undergo 3 years further training at the senior registrar grade in order to obtain accreditation from one of the Royal Surgical Colleges (see paragraph 15).

19. More recent history shows that the development of specialism in dentistry has followed the path set by medicine, particularly with respect to the difficulties experienced by the GMC in relation to European law. This culminated in reports from the Chief Medical Officer and, more recently, the Chief Dental Officer. In paragraph 21 of the CDO's Report (May 1995), 'UK Specialist Dental Training', it is stated that '*We believe that it is important that dentists who take up consultant posts in the NHS should be able to demonstrate that they have successfully completed a programme of higher specialist training*[3] *and that the arrangements for the appointment of consultants in dental specialties should mirror those proposed for the medical specialties. It is recommended that in the future no dentist may take up an appointment as an NHS consultant in a dental specialty which has been recognised by the GDC unless his/her name is included in the specialist list*'.

20. It is relevant to examine the proposals for the medical specialties. The Task Group acknowledges the recommendation in the report from the Department of Health's Working Group on Specialist Medical Training (1993), better known as the 'Calman Report', that '*the UK Certificate of Completion of Specialist Training (CCST), be awarded by the GMC on advice from the relevant Medical Royal College that the doctor has satisfactorily completed specialist training, based on an assessment of competence, to a standard compatible with independent practice*[4] *and eligibility for consideration to a consultant post. In making this recommendation the Working Group acknowledges the need to distinguish between the completion of specialist training as indicated by the award of the CCST and continuing medical education, which should extend throughout a doctor's career*'. It is clear that the medical specialties do not contemplate the need for further training following the award of a CCST.

21. It is also clear from the CDO's statement that '*arrangements for the appointment of consultants in dental specialties should mirror those proposed for the medical specialties*' and from more recent comments, that a Certificate of Completion of Specialist Training is precisely what it says: the completion of training.

22. The relationship between the dental and medical specialties is worthy of further consideration. Parity with medicine is strictly a secondary care phenomenon as it has never existed in the primary care setting. However, parity in secondary care is essential for the recruitment of future consultants and teachers and for the status of the dental profession as a whole. Even allowing for the development of training in other locations, hospital based teaching will still be needed and those who teach must be on the same footing as their medical peers. This is a matter which should be of very great concern, not just to orthodontists in hospitals and universities, but to the whole of orthodontics and dentistry.

[2] The JCHTD, concerned with senior registrar training leading to NHS consultant appointment, was replaced in June 1995 by the Joint Committee for Specialist Training in Dentistry (JCSTD) with wider responsibilities for dental specialist training.

[3] Currently, the term 'higher specialist training' refers to post-M.Orth. senior registrar training. However, in the future and in the context of the CDO report, the term refers to the training to be undertaken by specialist registrars. This new grade will combine the present (pre-M.Orth.) registrar and post-M.Orth.) senior registrar grades.

[4] The term 'independent practice' is defined in the Calman report as '*unsupervised responsibility for patients*', regardless of setting (hospital, practice, clinic, etc.). This is, in contrast, to the restrictive interpretation where independent practice equates to private practice.

23. The Calman Report is relevant to the consideration of standards. In the section 'Training: Structure, Length and Content', one of the 'three central principles' stated that '*any changes proposed must ensure that standards of both medical training and clinical service to patients are maintained or improved*'. Furthermore, the recommendation paragraph '*welcomes the opportunities created for a significant reduction in the duration of training, without compromising standards*'. Clearly, these statements place a duty on those responsible for specialist training to maintain standards.

24. Also relevant is the earlier report from the Chief Dental Officer, 'Training for Dental Specialists in the Future' (January 1994). This report was from the Working Group on Specialist Dental Training, chaired by the CDO, Mr R. B. Mouatt. In the paragraph entitled 'The Purpose of this Report', it is pointed out that the GDC proposals of November 1992 '*related solely to specialist practice outside hospitals and dental schools, whilst the Working Group have considered such practice in all locations, including hospitals and dental schools*'.

25. The CDO's first report contained annexed reports from three Sub Groups, one of which dealt specifically with orthodontics. The Sub Group for Orthodontics, chaired by Dr M. H. Seward, made a number of specific recommendations for the training of orthodontic specialists in the future. The Sub Group unanimously agreed that '*training standards should not be lowered to accommodate minimum EC requirements for specialist training*' and recommended that '*higher specialist training in orthodontics should normally be for five years*'. It further specified that a '*shorter higher training programme of four years was considered impracticable*' for several reasons, and that '*the present M.Orth. was not considered a suitable indicator for the CCST UK to be awarded*'.

26. Whereas it has repeatedly been stated that the new arrangements for specialist lists are intended to regulate the development of dental specialties outwith the hospital service, with implicit further training for hospital consultants and teachers, it is now apparent that the standard required for specialist registration (CCST) has to be '*compatible with independent practice and eligibility for consideration to a consultant post*', i.e. without the need for further training post CCST, and '*without compromising standards*'.

Duration of Specialist Training in Orthodontics

General factors

27. Orthodontics is fortunate in that its training programmes have evolved for over 40 years in keeping with the international development of the specialty. Many aspects of orthodontic training in the UK have worked very satisfactorily and the Task Group believe it to be the envy of other dental specialties in the UK.

28. It should also be recognized that whilst dentists who have completed the present 3-year M.Orth. programme are technically competent to diagnose and treat a range of malocclusions without direct clinical supervision, this level of technical competence does not indicate an ability to meet every clinical and administrative challenge which may beset a principal practitioner in independent specialist practice, whether in a 'high street', hospital, clinic, or any other setting.

29. It is relevant to consider paragraph 46 of the CDO's May 1995 report, and a report from the University Teachers Group of the British Orthodontic Society produced in September 1994 in response to the GDC's document on undergraduate education 'A Strategic Framework or Dental Education'. The Chief Dental Officer stated, as one of the justifications for his proposed three year period of higher specialist training for most specialties, that this training will be built upon the foundation that '*during the clinical part of an undergraduate dental course students carry out sufficient work to be deemed safe when they qualify*'. However, as far as orthodontics is concerned, this is at odds with the report from the University Teachers of Orthodontics. Having discussed the undoubted limitations of traditional removable appliance techniques, the well documented superiority of fixed appliance therapy, the increasing use of fixed appliances in the GDS, the concentration of 55 per cent of GDS orthodontic treatment in the hands of 1.8 per cent of dentists (mostly specialists), and the observation by the Dental Practice Board that very little orthodontic treatment is carried out by GDPs in the first 10 years following qualification, the report concluded that '*the undergraduate orthodontic curriculum should reflect the pattern of UK orthodontic care. The programmes should aim to provide an education in orthodontics as opposed to a training in techniques that, because of their limitations, are not indicated for most patients and are not practised by most GDPs*'. Furthermore, the report presented the results of a survey which revealed that the '*the aim of most of the orthodontic courses, following the 40% manpower reduction in orthodontic teachers (Howat, 1990), is to provide a longitudinal illustrative use of fixed and removable appliances, so that the student experiences an education in appliance use as opposed to a training in active treatment*'. The Task Group does not suggest that dental graduates are not safe, as this can be achieved through a process of education to enable graduates to recognize their limitations and the need to seek advice or referral for treatment in the majority of orthodontic cases. However, there is clearly no justification for any assumption that specialist registrars will have obtained a firm foundation of clinical training in orthodontics at the undergraduate level.

30. The outcome of many dental procedures cannot be assessed until many years after their completion. However, it is reasonable to expect any training programme to be long enough to allow the completion of active appliance treatment for two 'generations' of patients, the first being 'routine specialist cases' and the second being 'complex specialist cases'. Thus, the training programme should be at least twice the time taken to treat specialist cases. Whilst not intending to dissociate itself from other branches of dentistry, orthodontics is unique in that the educational feedback from the treatment of specialist cases is not fully available for 24–30 months. Treatment planning, preliminary dental work and settling the patient into a retention regime adds to the time taken to manage cases. On this premise, the duration of clinical training should be 60 months for orthodontics.

Specialist practitioners

31. The standards of training and the requirements for appointment to consultant orthodontist posts within the NHS have been applied rigidly for a number of years. Requirements have also been established for appointments as senior dental officer in orthodontics in the CDS. However, it is appropriate to consider the training requirements for specialist practitioners.

32. It seems clear that despite the essential roles played by orthodontists in the HDS, CDS and universities, the largest group within the specialty, treating the most patients, will be in specialist practices operating within a primary care setting. These specialists will also need to acquire teaching skills if they are to fulfil their role as future trainers. It also seems very likely that the nature of orthodontics will continue to change with specialist practitioners at the forefront of these changes.

33. The rise in adult orthodontics is set to continue, bringing with it many clinical complexities involving other specialist disciplines. The public in the next century will be looking for quality care, recognising the benefits of specialisation, whilst expecting co-ordination of these skills to meet their overall dental needs.

34. The recognition that practitioners, whether generalist or specialist, also run businesses is long overdue. To some extent, it is anticipated that this shortcoming will be rectified in the period of General Professional Training. However, many areas are specific to specialist practice. The following list is not exhaustive, but is intended to give an indication of areas to be included in the training programme: Organization of practice, management of referrals and waiting lists, use of auxiliary personnel, audit, stock control, cross-infection, radiation regulations, COSHH assessments, NHS administration, relationships with referring practitioners and local orthodontic, maxillofacial and restorative consultants, role of Health Authorities and Local Dental Committees, staff management and training, Health and Safety, Tax and National Insurance, private patient financial control, ethics, practice financing, practice and personal insurance, pensions, legislation, etc.

Hospital consultants and university teachers

35. The public in the United Kingdom is fortunate in having an established network of NHS consultant orthodontists whose training is designed to meet the demands of that appointment. Besides clinical responsibilities, the consultant also discharges an advisory and teaching role throughout the specialty and dental profession. In particular, many consultants are actively involved in the training of future specialists. These arrangements are comparable to those of their medical colleagues.

36. It is quite simply not possible to train specialist registrars to be competent in the management of patients with malocclusions requiring major maxillofacial surgery or patients with craniofacial anomalies such ass cleft lip and palate in less than five years. It also takes at least 5 years to acquire the teaching, research, and management skills necessary for a successful career as a university teacher or consultant in the hospital service.

Community orthodontists

37. Orthodontists in the CDS share common ground with specialist practitioners and hospital consultants. They support the primary care service provided by community dental officers by providing advice and treatment planning for simple malocclusions and treatment for complex cases. In the absence of specialist practitioners, they may provide a treatment service to GDPs.

38. However, in addition to most of the skills described in the previous paragraphs, community orthodontists need to acquire an understanding of epidemiology and social issues, general and local, that are relevant to providing a safety net for certain sections of the population. More specifically, the CDS orthodontist is often required to advise and treat patients with physical or mental disabilities and high orthodontic need. Other patients are seen in institutional settings (e.g. in residential schools), or may live in remote locations for whom contact with the specialist is infrequent. The CDS orthodontist may also collect epidemiological data and will advise the district dental officer or director of dental services on orthodontic matters. As with specialist practitioners, this group will need to acquire teaching skills if they are to fulfil their role as future trainers.

European aspects

39. Whilst acknowledging the GDC's role as the sole competent authority, it should also be recognized that the supervision of training posts by a national and independent Specialist Advisory Committee for Orthodontics and Paediatric Dentistry (hereafter referred to as SAC), and the system of examinations set by the Royal Colleges are great assets. Both the national supervision of training and the system of college examinations are supported in a survey of university teachers, and are also highly respected by the organisers of training programmes in other EEA countries. Indeed, this has led to successful diets of the M.Orth. examination in the Netherlands, held by the Royal College of Surgeons of Edinburgh. It is anticipated that the UK competent authority would not wish this important contribution to European training standards to be diminished.

Conclusions

40. We are aware that both the CMO and CDO advocate a reduction in the length of training where possible. However, 'compressibility' of the programme, as opposed to the entry requirements, should not be taken-for-granted as much orthodontic training already takes place as a well structured course, and not as an apprenticeship as commonly found in medicine and dentistry. It is also appropriate to note that the Calman (CMO) report stated clearly that any shortening of training should not be associated with a lowering of standards.

41. The reduction of the pre-specialty period from the (typically) current four years to two years of General Professional Training, including basic science, is welcome. However, it would be wrong to believe that certain components of specialist training can be moved from the present M.Orth. programme into GPT, as hinted in the May 1995 CDO report (paragraphs 42 and 46), or to believe that specialist training builds on a firm base of undergraduate clinical training in orthodontics, as justifications for a short training programme. A reduction from the current 6-year training (sometimes 7 years when time is spent seeking a senior registrar post) to a seamless 5-year programme,

enabling an overall reduction from 10 or 11 years to 7 would be of benefit to all concerned, without sacrificing standards to some lowest common denominator.

Recommendations

42. Although future specialist will not experience identical training, with differences of emphasis in the latter stages of training, we recommend that all future specialists have equal status and be eligible to apply for consultant posts. The enhanced flexibility between specialist practice, hospital and community clinic would be beneficial at a local level where service provision could be more responsive to local needs than at present.

43. Whilst it is acknowledged that the higher specialist training pathway for consultancy in orthodontics has to be reduced from the present 6 years to 5, it is the clear and unanimous view of the Task Group that 5 years is the minimum period of structured higher specialist training required for specialists aspiring to careers in the hospital service or universities, or to be fully competent for independent practice as specialist practitioners or community orthodontists.

44. The Task Group proposes that, in future, the award of a CCST and inclusion on a specialist list for orthodontics should be based upon the attainment of a royal college orthodontic qualification, registered with the GDC, awarded after the successful completion of 5 years approved clinical, theoretical, and management higher specialist training.

Training Locations

45. The Task Group endorses the view that diversity in the location of specialist training, including specialist practices and community clinics, would be desirable. However, this diversity should not be seen as preparing the future specialist for a career limited to any one particular location. The differences should be those of emphasis, preserving the new specialists freedom to select their ultimate working environment once awarded a CCST. Career changes and part-time work in more than one environment are anticipated. It would be up to consultant appointment committees to determine the suitability of applicants for the post in question (but see paragraph 106 regarding the appointment of applicants awarded a retrospective CCST).

46. We note the suggestion that specialist training '*will increasingly move outwith hospitals*' (CDO report, May 1995, paragraph 30). We are concerned by the possible interpretation that training in the 'new locations' could almost replace the present excellent structured training undertaken within district general hospitals and dental schools. It would be quite wrong to believe that modern orthodontic specialist training can take place as a form of craft apprenticeship with weekly day-release for lectures and seminars. The following sub-section aims to place training in specialist practices in perspective.

Training in the 'High Street'

47. Specialist practitioners, however clinically able, are not equipped to provide training in the academic and research areas of orthodontics. Similarly. they have neither the knowledge, experience, or ready access to the multi-disciplinary clinical and administrative facilities essential for the management of complex cases such as cleft lip and palate, and other syndromes.

48. It is therefore envisaged that even for specialist registrars opting for a training emphasis in a specialist practice environment, no more than five sessions a week during the third, fourth, and fifth years of training should be spent in the high street (see paragraph 58).

49. Suitable training practices and specialist trainers would have to be identified. Training practices would require inspection by the SAC and courses provided for initial instruction of trainers.

50. It is also assumed by some that there exists a large pool of specialists able and willing to undertake these training responsibilities. In our view, the number of specialist practitioners able to undertake this task at the present time is relatively small. Undoubtedly, more could be trained to fulfil this role, but, anecdotally, it seems that many potentially suitable specialists would be unwilling for reasons described in the following two paragraphs. It would be desirable for any specialist practitioners involved in the training of specialist registrars in their practices also to have part-time attachments at a dental school or district general hospital.

51. For many orthodontic specialist practitioners, taking on a training role may necessitate internal structural practice alterations or a move to larger premises. This could apply to any practice, but is more likely to apply to smaller or single-handed practices, as commonly found in orthodontics. Furthermore, most specialists, whether single handed or in a group practice, are very busy, with full books and long waiting lists. The major logistical upheaval of reorganizing a practice in terms of either physical structure or administrative procedures could be a potent disincentive, with many practitioners unwilling to make the effort to integrate training into their busy schedules.

52. Adequate financial arrangements would need to be made in order to overcome a commonly held view that rates of pay for part-time visiting staff are inadequate, together with lack of reimbursement of overheads and expenses whilst practices are unattended. These overheads may even exceed the salary obtained, resulting in net financial loss. Within practices, financial arrangements would also need to be appropriate, as goodwill and professional satisfaction alone are unlikely to provide sufficient motivation for all but a handful of potential trainers. Training in the 'high street' should not be taken for granted as a cheap option.

First and second year training locations

53. We believe that the focus of the first and second years of training should be in the dental school, although a proportion of clinical training could take place in other locations. During this time theoretical knowledge would be acquired and the research aspect of training would be undertaken. At the end of 2 years, an examination in orthodontic theory would be taken with written papers, and this would be the earliest point for the presentation of a research dissertation. There would, of course, be clinical training during this period, with patients treated at the university main base and, if appropriate, at other regional locations. Basic specialist skills would be acquired during this time.

Third, fourth, and fifth training locations

54. During the third, fourth, and fifth years, specialist registrars would be taking on more complex cases, and consolidating their clinical experience over a wide range of malocclusions and working environments. It is at this time that greater diversity in training locations would begin.

55. We believe that during the third, fourth, and fifth years of training, all specialist registrars should spend at least 1 day a week away from clinical practice, either at the dental schools or at their local district general hospital postgraduate centres. The exception would be in the third year, when some of the time would be used clinically to complete the treatment of cases begun at the dental schools. At this stage, the emphasis in the dental schools should continue to be on education rather than training, focusing on lectures, seminars, group discussions, and research guidance.

56. Specialist registrars would, in their third year, be encouraged to follow-up their research projects with the preparation of papers for publication or presentation at a scientific meeting. Such an involvement in original work has been shown to encourage an attitude for continuing professional development on completion of initial research training and this should continue to be an essential feature of the seamless training programme.

57. In the fourth and fifth years, the study day would be devoted to training in the many academic and non-clinical subjects identified in the SAC curriculum. These would vary according to the selected emphasis in training environment, whether in hospital, specialist practice, community clinic, or dental school. However, there should be a degree of crossover of content such that all future specialists would have an adequate level of knowledge of community matters, hospital administration, and practice management.

58. For specialist registrars opting for training emphasis in a specialist practice environment, the appropriate ratio would be four or five clinical sessions in practice, three or four clinical sessions at a DGH and two sessions for study and seminars at the dental school or, in some cases, the local postgraduate training centre. The treatment service provision could be a source of funding for the practice whilst the specialist registrar remains on a salary. The sessions at the DGH would be intended to improve overall clinical skills and to provide experience in the scope of multidisciplinary care.

59. For specialist registrars opting for training emphasis in a hospital environment, it is anticipated that not less than five sessions would be spent in the DGH and three to five sessions at the dental school. It would also be desirable for up to two sessions to be spent in a specialist practice or clinic.

60. For specialist registrars opting for training emphasis in a community clinic environment, an appropriate ratio would be four or five sessions in community clinics, two to four sessions in a DGH and two sessions for study and seminars. As in the previous paragraph, it may be appropriate for this group to spend up to two sessions in a specialist practice. The sessions at the DGH would serve the same purpose as described in paragraph 58.

61. For specialist registrars opting for training emphasis in a dental school environment, an appropriate ratio would be to spend six to eight sessions at the dental school and two to four sessions in a DGH. The case for training in specialist practices or clinics is less strong for specialist registrars with declared ambitions for university teaching and research, although this possibility should not be excluded. During this period, work could begin towards obtaining a higher research degree (PhD or DDS).

Examinations Schedule

62. It is not within the remit of the Task Group to make detailed recommendations on the schedule of examinations to be undertaken by specialist registrars in the future. However, it is appropriate to pass comment in terms of general principle.

63. It is essential that the assessment of trainees fulfils the GDC requirement that the standard expected of specialists should be established by their peers. Part of this assessment includes the supervision of training posts by the SAC, which is now composed of representatives from all spheres of the specialty. Additionally, whilst it is entirely appropriate for the academic part of the examinations to take place within dental schools, and perhaps form part of a university degree, we believe the only satisfactory way of providing a national standard for specialty practice determined by peers is through inter-collegiate examinations.

64. At the end of the second year, an examination in theory and research would be taken with written papers and research dissertation. We envisage this examination could be a university degree.

65. At the end of the third year. Part 1 of an intercollegiate examination would be taken, with a clinical emphasis involving the examination of new patients, vivas', and diagnostic tests. It would be desirable for the academic and research content of the examination suggested in the previous paragraph to be recognised by the Royal Colleges, so that further written papers would not be necessary.

66. It is appropriate that the main examination takes place at the stage of awarding the CCST. The completion of training would thus be marked by the successful completion of Part 2 of the royal college examination in the fifth year. This would involve the presentation of case records and log diaries to demonstrate breadth and depth of clinical experience, and vivas to assess the candidate's knowledge of all areas of orthodontics, particularly those relevant to their selected training emphasis.

67. The royal college qualification and the completion of five years of training would be recognised by the GDC as adequate evidence for the award of a CCST and inclusion on the specialist list for orthodontics.

68. Within these suggestions, the M.Orth. 3-year registrable qualification would no longer be available, although many of its proven features would be retained in the proposed new schedule of examinations.

69. It would remain open to the dental schools to offer training programmes and qualifications to meet the needs of non-EEA overseas postgraduate students, but without necessarily fulfilling the requirements for award of a CCST.

Part-time Training

70. The Task Group fully endorses the concept of part-time training.

71. The relevant clauses in EC Dental Directive 78/687/EEC of July 1978 are paragraphs 1 and 2 in Article 3, as follows:

> *1. Without prejudice to the principle of full-time training as set out in Article 2(1)(c), and until such time as the Council takes a decision in accordance with para - graph 3, Member states may permit part-time specialist training, under conditions approved by the Competent national authorities, when training on a full-time basis would not be practicable for well founded reasons.*
> *2. the total period of specialised training may not be shortened by virtue of paragraph 1,. The standard of the training may not be impaired, either by its part-time nature or by the practice of private, remunerated professional activity.*

There is ambiguity in the first sentence of the second paragraph as to whether this is intended to signify that the *period* of training may not be reduced in years, or whether it is the total number of sessions or hours of tuition that cannot be *shortened.*

72. The SAC has evolved programmes for part-time training. The longitudinal nature of orthodontics is such that time in years of training is more relevant than total hours or sessions of tuition. We are therefore in favour of the SAC view that part-time training on the basis of six sessions per week should take 6½ years, instead of the strictly *pro rata* duration of 8 years and 4 months.

73. The details of part-time training programmes would need approval and monitoring in the usual way.

74. It is anticipated that part-time training would be funded under arrangements similar to the funding of full time training.

75. It is a point of principle that access to specialist training, whether full or part-time, should be based on merit, not on the trainee's ability to finance this training.

Manpower

76. We welcome the increase in future training places requested by the SAC and approved by the Manpower Advisory Panel of the Faculty of Dental Surgery of the Royal College of Surgeons of England. The new number of 195 training places recognises the present inadequate supply of specialist treatment, and the unmet need identified by the 1983 and 1993 Child Dental Health Surveys. It is also noteworthy that the 195 training places have been agreed by the Specialist Workforce Advisory Group (SWAG) following a recommendation from the NHS Executive manpower planning department. It should be understood that the figure of 195 represents an intended number of funded training places, not the annual output of specialists. For example, the annual output would be 39 from 5 years' training.

77. A training output of 39 specialists per annum would be a good improvement on the present situation. It is thought that approximately nine orthodontists per year currently enter specialist practice, not quite keeping pace with the numbers retiring. Once the requirements to maintain present manpower in the salaried services (universities, HDS, CDS, armed forces) have been met, the number of specialists available for specialist practice should more than double to between 20 and 25 per year.

78. The British Orthodontic Society has endorsed the recommendation in an unpublished report from an Expert Working Group prepared for the Standing Dental Advisory Committee (SDAC) in 1992 that an appropriate manpower level would be 480 specialist practitioners. This figure was based n data including the following:

- projected 12 year old population in the year 2000.
- current child and adult treatment levels in the GDS, HDS and CDS.
- unmet need as determined by the 1983 Child Dental health Survey.
- treatment priorities defined in the Index of Treatment Need (IOTN).
- an assumption that 28% of GDS orthodontics will continue to be carried out by GDPs.
- an estimated caseload for orthodontists working to high clinical standards.
- available assistance from auxiliaries permitted to carry out intra-oral procedures.

It is stressed that the planned level of 480 specialist practitioners is dependent on the preservation of current numbers in the HDS and CDS and on the creation of orthodontic auxiliaries.

79. Whilst we agree, on present knowledge, on the desirability of aiming for a goal of 480 specialist practitioners, we believe that frequent review of manpower levels and number of training places would be appropriate for the following reasons:

(a) The number of registered specialists through grandparenting is still unknown,
(b) The impact of orthodontic auxiliaries needs to be assessed.

Once the desired number of specialists has been reached and the new requirement is then to maintain a balance, it becomes difficult, and indeed painful, to reduce the course sizes. Whilst a dash for growth may be attractive in the short term, steady progress may be preferable.

80. The Task Group carried out a small survey by contacting the orthodontic heads of department of all the UK dental schools, in order to gauge the adequacy, or otherwise, of resources to meet their current training responsibilities:

- All schools, despite significant loss of academic staff (see paragraph 29), are managing to maintain their training programmes by relying on hospital consultant orthodontists. Major city departments were more likely to employ part-time university teachers (usually specialist practitioners) and, in some provincial departments, senior registrars were given teaching responsibilities.
- Those departments that trained non-EEA overseas postgraduate students all stated that the university funding so generated was crucial to the survival of their programmes.
- Provincial departments were generally anxious that inadequate staffing and resources would prejudice their programmes for the proposed increases in their specialist registrar allocation, whereas the major departments in London were concerned by a reduction in their number of trainees, especially where they have the capacity to train greater numbers.

81. Although much clinical training is undertaken by consultants and some is undertaken by specialist practitioners, the increased number of training places will require adequate university teacher manpower in the dental schools. It should not be overlooked that, at present, the university teachers' main responsibilities are research and undergraduate teaching, especially as dental school funding is determined, in part, on research output. This imposes a pressure which conflicts with the desirability of recruiting specialist practitioners as part-time clinical lecturers, as these generally have little or no research output.

82. There is a major service commitment to training and it should be recognized that during their training, specialist registrars will be providing orthodontic treatment to patients in all three branches of the service, thereby helping to meet the orthodontic needs of the population. Thus, a training programme leading to a CCST after 5 years need not have a particularly adverse effect on the provision of orthodontic services.

83. The current reforms in the NHS involving market place principles for the provision of care under a purchaser/provider system are understood. However, the Task Group would view as sinister the application of market forces to the provision of training as it is clear that this requires strategic national planning. This would not be compatible with market place principles and a request is therefore made for negotiated specialist training places and pathways to be managed centrally. Such management would not be incompatible with local funding.

Specialist Registration

84. The proposed training requirements for prospective inclusion on a specialist list have been presented in previous sections. This section will address other areas of principle attached to specialist registration.

85. The Task Group endorses paragraph 21 of the GDC's revised proposals of November 1992. This paragraph is reproduced in full:

> *The following principles should apply:*
> *(a) In order to ensure the necessary continuing responsibility for the patient's oral and dental health referral would be through general dental practitioners or community dental officers. This would not preclude referral by dentists within hospitals or self-referral of patients not under the care of a general dental practitioner.*
> *(b) Any specialist list should be indicative, not restrictive, i.e. holders of specialist titles should not be precluded from undertaking treatment which falls outside their specialist sphere, while generalists should remain free to practice across the whole spectrum of dentistry,*
> *(c) The standards expected of specialists should be established by their peers.*

86. Further to the previous paragraph, the aspirations of specialists must not conflict with the legitimate rights of general dental practitioners to advise patients on orthodontic matters and carry out any treatment within their competence. Further training for general dental practitioners in specialty subjects is to be encouraged as, apart from direct benefits to patients, this has been found to improve the quality of referrals. The implication of GDP training on training resources will need to be considered[5].

87. It is very clear from experiences in North America and Australia, that the effective use of expanded duties auxiliary personnel for orthodontics requires significant training for the dentist as well as the auxiliary. Many of the treatment procedures can be carried out for the orthodontic patient by either the dentist or the trained auxiliary, and the need to adopt an effective team approach is crucial to the effective delivery of care. On the one hand, the availability of orthodontic auxiliaries can enhance treatment standards and reduce treatment costs. On the other hand, inadequate training in the use of auxiliaries or inadequate supervision could lead to a reduction in quality. It would therefore be prudent to restrict the deployment of orthodontic auxiliaries to those dentists and specialists who had received suitable training.

Transitional Arrangements

88. The requirements for the award of a CCST and inclusion onto a specialist list for orthodontists in the future have been defined in previous sections. However, as it will be necessary for registration to be both prospective and retrospective, it is appropriate to consider who, among present practising orthodontists, would be able to register as specialists.

89. The Task Group notes the recommendations made by the GDC in its revised proposals of November 1992. For completeness the entire paragraph 15 is reproduced:

> *It is recommended that the Council should establish an Advisory Committee, under Article 11(8) of the Rules and Regulations, for an initial period of two years, to assist the Registration Sub-committee in dealing with the implementation of specialist titles. The Chairman of the Sub-committee would chair the Advisory Committee which would include two representatives of Orthodontics and Oral Surgery and three of Restorative Dentistry (one for each discipline), appointed by the Council on the advice of appropriate bodies, as well as another member of the Council. The Advisory Committee's remit would be to scrutinise and advise on applications made under 'grandparent' clauses, to advise on the suitability as qualifications for entry on a specialist list of any new diplomas developed by awarding bodies and to put forward proposals for the method of implementation of continuing education requirements.*

It appears from recent reforms within the GDC that such an advisory committee would be accountable to the

[5] Failure to provide adequately for this need serves to encourage the proliferation of 'weekend' courses promoting inappropriate diagnosis and treatment methods for the majority of malocclusions. These techniques have proved popular among susceptible undertrained GDPs but are almost universally rejected by those who have gained structured theoretical and clinical training, and have an understanding of the refereed literature.

newly created Specialist Training Advisory Committee (STAC)[6].

90. We see a role for an advisory committee both for the initial transitional period, as well as over the longer term. It is our view that the structure proposed is very suitable for any longterm advisory role including the assessment of new diplomas or degrees, the implementation and monitoring of continuing education, and the assessment of applicants from overseas.

91. However, it seems likely that the specialist lists for the other specialties will not be introduced at the same time. In this respect, orthodontics has been seen as a vanguard specialty and there is a real possibility that the orthodontic list would be the first to be set up. In this circumstance, we would recommend the setting up of an advisory committee more specifically dedicated to orthodontic requirements, with the primary role of assessing UK grandparent applications. For the purposes of this report, we will refer to this body as the Transitional Advisory Panel for Orthodontics which would be set up by, and accountable to, the STAC.

92. The Task Group fully endorses the GDC's proposal (November 1992, paragraph 13) that '*transitional arrangements should operate for no more than two years*'.

93. Fortunately in orthodontics, there has been specialty training for several decades, albeit through 1- or 2-years courses as opposed to the current 3 years. However, these 1- and 2-year courses were the accepted standard of the day. The majority of consultant orthodontists, orthodontic practitioners and community orthodontists in clinical practice at the present time obtained their qualifications following one or two year courses. The value of clinical experience and any training which took place after obtaining the D.Orth. or similar qualification also need to be taken into consideration.

94. The General Dental Council has already assessed the value of experience when issuing specialist certificates for those who wish to practice their specialty in the EEA. The GDC's 'Notes on Specialist Certificates' state: '*provision is also made for the issue of a certificate to a dentist whose course of training in the specialty was completed prior to the implementation of the Dental Directives and was shorter than three years duration. A certificate may be issued if the dentist can show that he has been practising in the specialty subsequent to his course for a period equal to at least twice the difference between three years and the length of his specialist training*'.

95. Applicants who hold a consultant contract, royal college accreditation or an M.Orth. qualification should be eligible for inclusion on the specialist list.

96. Applicants who hold a 1- or 2-year D.Orth. or equivalent qualification and are currently engaged in the exclusive practice of orthodontics and have clinical experience for the period defined in paragraph 94 should be eligible for inclusion on the specialist list.

97. There are also in the United Kingdom a few practitioners who have limited their practice to orthodontics without any postgraduate qualifications, but who are regarded by their peers as specialists. It is proposed that for applications received within the introductory 2-year period, such cases are also considered on their merit for inclusion onto a specialist list. Applicants would be expected to have extensive clinical experience and be able to demonstrate active participation in process of continuing education. Their curriculum vitae should show a satisfactory level of attendance at conferences, courses or study circles and subscription to orthodontic journals.

98. The continuing education process described in the previous paragraph would in fact be expected from any member of the specialty. In view of the lack of formal training for this group, the amount of contact with the local consultant and, in particular, any period of clinical supervision such as during an attachment as clinical assistant would be most relevant.

99. Whilst a degree of generosity is appropriate to grandparenting arrangements, there is also a duty to uphold standards and protect the public which has an expectation that any practitioner on a specialist list has acquired sufficient knowledge and skills.

100. Applicants could, at the discretion of the Transitional Advisory Panel for Orthodontics, be required to undergo further training and/or examination to assess clinical competence. This would be subject to the setting up of a mechanism for assessment by the GDC in consultation with the Royal Colleges. The Task Group considers that these provisions would apply only to a relatively small number of dentists at present working in the UK without formal postgraduate qualifications.

101. To assist the Transitional Advisory Panel further, we offer guidance for the assessment of dentists in exclusive or almost exclusive orthodontic practice without a registrable orthodontic qualification. Although this guidance is based upon the applicants' years of experience, it is stressed that the assessment of all dentists within this group should be carried out on an individual basis.

1. *Dentists with 15 or more years of experience at the beginning of the transitional period*[7]. It is anticipated that these dentists would be eligible for inclusion on a specialist list provided they meet the criteria for continuing education described in paragraph 97.
2. *Dentists with 7 to 14 years of experience at the beginning of the transitional period*. We believe that for this intermediary group, greater scrutiny would be required in terms of continuing education as described in paragraph 97 and clinical supervision as described in paragraph 98. It is for this group in particular that the Transitional Advisory Panel for Orthodontics may wish to arrange further training and/or examination to assess clinical competence as described in paragraph 100. Some applicants with 7–9 years of experience may be affected by further recommendations in sub-section (c) below.
3. *Dentists with under 7 years of experience at the beginning of the transitional period*. It is our view that these dentists should not be included on a specialist list as it would be unacceptable for dentists to be registered as specialists without formal training at an earlier date

[6] The STAC is a new GDC committee. Its functions will include advising the Education Committee on CCST awards (on RCS recommendations), on the implementation of transitional arrangements, and on the establishment of appeal mechanisms.

[7] The period of 15 years was first proposed in the joint report from the orthodontic societies in April 1990, referred to in paragraph 14 of this report.

than contemporaries undergoing the full specialist training programme, often at personal financial sacrifice. The reason for a 7-year period is that the duration of training for registrars and senior registrars in post is 6 years with the addition of a further year prior to commencing training as applications for courses beginning in October are submitted before the end of the preceding year and interviews held shortly after.

In addition, it is recommended that no dentist be included on a specialist list through the transitional arrangements within the first 10 years of graduating as a dentist. The reason is that, at present, the majority of successful applicants entering specialist training have been gaining experience in dentistry and have obtained a full FDS qualification which, by regulation, cannot be achieved less than three yeas following basic qualification. It is thus almost impossible for a specialist training to consultant level to obtain his or her royal college accreditation in less than ten years from the date of initial qualification. It would therefore be unacceptable for dentists not undergoing specialty training to join a specialist list in a shorter time.

102. An appeals procedure would need to be available to the unsuccessful applicant who falls within the groups of dentists defined in paragraphs 96 to 101.

103. Following the transitional period, only applicants with a CCST or overseas applicants (particularly EEA) with appropriate training and qualifications would be eligible for inclusion on the specialist list, with the exception of the small number of potential applicants identified in paragraphs 104 (2,a) and 105.

104. It is necessary to consider the position of those undergoing training at the time of introduction of the specialist list. Essentially, there are two categories of trainees:

1. Those undergoing post M.Orth. senior registrar training should be allowed to continue their training, as guided by the SAC, and awarded a CCST upon successful completion of this training. It may be appropriate for those in the early part of their senior registrar training to have their duration of training reduced (to no less than 2 years), subject to agreement between the SAC and the GDC, as the competent authority.
2. Those undergoing pre M.Orth. registrar training should be given the following options:
   (i) They could gain access to the specialist list at the M.Orth. stage by virtue of retrospective grandparenting, even if this extends beyond the 2-year transitional period. However, this group would not have the level of training or experience envisaged for appointment to a consultant orthodontist post as described below in paragraph 106.
   (ii) Alternatively, a further period of training should be made available in order to obtain a prospective CCST. The exact period and nature of this further training (at least 2 and at most 3 years) for this group would be subject to agreement between the SAC and the GDC, as the competent authority. The factors to be considered would include training location (seamless or not), and whether it is possible to integrate a revised SAC 5-year curriculum with the present M.Orth. training.

The Task Group believe it is appropriate for these future specialists, caught in the midst of transition, to be treated sympathetically, with sufficient funding and encouragement made available to allow them to complete their training up to prospective CCST level if they wish.

105. It is proposed that provision be made for a small number of UK trained orthodontists who possess a registrable orthodontic qualification, but who fail to apply within the two year introductory period. Examples would include those who have taken a career break or who have worked overseas and wish to return to the UK. At the discretion of the STAC, such applicants should be given the opportunity to demonstrate their commitment to the specialty by providing evidence of having undergone a process of continuing education.

106. It has previously been recommended that, in the future, all specialists should be trained to an equivalent level to fulfil their eligibility to apply for consultant posts, regardless of their ultimate sphere of practice. However, it should clearly be seen that the generous grandparenting arrangements proposed are intended to recognize specialization outwith the hospital service. This is unlike the arrangements for grandparenting in the medical specialties where a royal college accreditation level of training is required for inclusion on a specialist list. The Task Group therefore considers that it would be inappropriate for those included on the specialist list for orthodontics by virtue of grandparenting to be considered for appointment to a consultant post, with the following exceptions:

- Current or former holders of consultant contracts.
- Specialists holding royal college accreditation.
- Specialists without accreditation, but with an M.Orth. qualification and considerable experience in the areas required for the post in question.

We believe this concept to be important, particularly with reference to applying the central principle in the Calman report to the hospital orthodontic service to *'ensure that standards of both medical training and clinical service to patients are maintained or improved'*, (see paragraph 23 of this report). We recommend that the GDC ask the NHS Executive to issue suitable guidance to consultant appointment committees for the assessment of applicants who have been granted retrospective CCSTs.

107. It should be available to specialists included on the specialist list through grandparenting, but whose formal training as of 1 or 2 years' duration, to undergo additional full or part time training and sit the final specialist examination in order to 'upgrade' their training and qualifications.

Continuing Professional Education

108. The Task Group endorses the statement of policy on continuing postgraduate education (General Dental Council, May 1995) and supports the view that all those who wish to maintain their name on a specialist register in orthodontics should provide evidence of participation in professional education relevant to their specialist practice.

109. The Task Group supports the suggested level of 15–20 hours per year as laid out in the first report of the Council of European Chief Dental Officers (October 1994), but would greatly prefer a level of flexibility, such as

a requirement of 100 hours per 5 year period. This is very similar to the GDC proposals in November 1992 which suggests an '*equivalent of at least fifteen days over the previous five year period*'.

110. A mechanism will need to be set up to monitor compliance by registered specialists. It is understood that detailed consideration of CPE including course validation, regulation and funding is to be undertaken by other bodies. No doubt, the Royal Colleges and the British Orthodontic Society will wish to be consulted.

Postscript

111. There has been recent polarization of opinion on various aspects of future specialist training and transitional arrangements, often in our view, motivated either by perceived advantages to be gained by sectional interests, or as expediency to satisfy objectives based on factors other than educational and training requirements. When views are polarized, it is easy to read into any report supportive or antagonistic proposals, particularly when presented in the stark style of a list of recommendations. As described in the introduction, it was therefore decided not to produce such a list. The Task Group is grateful for having been given the opportunity to consider these matters thoroughly, in the wider interests of the dental profession, the orthodontic specialty, and the public in the United Kingdom.

Acknowledgements

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Appendix: Index of Abbreviations

BOS	British Orthodontic Society
CCST	Certificate of Completion of Specialist Training
CDO	Chief Dental Officer
CDS	Community Dental Service
CMO	Chief Medical Officer
COSHH	Control of Substances Hazardous to Health
CPE	Continuing Professional Education
DGH	District General Hospital
D.Orth	Diploma in Orthodontics
EEA	European Economic Area
EEC	European Economic Community
EU	European Union
FDS	Fellowship in Dental Surgery
GDC	General Dental Council

GDP	General Dental Practitioner
GMC	General Medical Council
GPT	General Professional Training
HDS	Hospital Dental Service
IOTN	Index of Orthodontic Treatment Need
JCHTD	Joint Committee for Higher Training in Dentistry
JCSTD	Joint Committee for Specialist Training in Dentistry
M.Orth	Membership in Orthodontics
NHS	National Health Service
RCS	Royal College of Surgeons
SAC	Specialist Advisory Committee in Orthodontics and Paediatric Dentistry
SDAC	Standing Dental Advisory Committee of the Department of Health
STAC	Specialist Training Advisory Committee of the GDC
SWAG	Specialist Workforce Advisory Group
VT	Vocational Training