Features Section

Guest Editorial

Specialist Training—Where is it going?

'I don't drop players—I make changes' Bill Shankly 1973.

Mud is a great leveller in most field sports and money is good at focusing peoples minds and attitudes. The football player wages supposedly being earned in specialist practice (Richmond, 1998), the prolonged delay on decisions about CCST by the GDC and clear disadvantages in higher training have led many trainees to choose a career in specialist practice. The training of postgraduates in orthodontics has traditionally been delivered in teaching hospitals and more recently the programmes have been linked to clinical instruction within district general hospitals. Academics have taken the lead in establishing these programmes, supported by able and committed NHS Consultants and specialist practitioners. The first MSc programmes in orthodontics in the UK began in 1974 at the Royal Dental Hospital and elsewhere the following year (Robertson, 1976). These changes persuaded the Royal Colleges to lengthen the DOrth Course to 2 years and the quality of training has improved steadily since that time. The beliefs of the leaders establishing these courses were fully justified and the benefits to individuals and to our speciality has been enormous. It is now almost been forgotten that the appearance of treated cases within the DOrth was entirely due to the efforts of a group of consultants and academics, whose protocol for case presentation was subsequently adopted wholesale by the Colleges for their basic orthodontic specialty examination. (Treatment Study Group of the BSSO, 1977). Subsequently the decision of the BJO to publish good quality case reports to demonstrate the improving clinical skills achieved by trainees has added further emphasis to the quality of treatment within these training programmes. The quality of the research reports organised by the University Teachers Group at the British Orthodontic Conference also demonstrates a continuously improving standard and a will to embrace a wide range of scientific approaches in producing research reports. Indeed the postgraduates on the first Bristol MSc/MOrth course (5 in total) produced 22 full publications in peer reviewed journals as well as a book. The latter has proved extremely popular with postgraduates if not their teachers. The second course has already exceeded the total grants obtained by the first course by an order of magnitude. The trainees are clearly capable of delivering both academic and clinical excellence, but with lack of incentive and obvious disadvantages in further training, who will shape the specialists of the future? Already the number of Chairs in orthodontics has declined from fourteen to seven. Most of this reduction has been because no suitable applicants could be found. More worryingly the number of lecturers in training (without consultant status) has also halved over the past ten years. While academic appointments have always been unpopular, consultant posts are now similarly out of favour. Key to this, is the attractiveness of training in orthodontics beyond the CCST within the NHS. The trainee has to enter a structured two year fixed term training appointment (FTTA). These posts represent a shortened old style senior registrar training and are marked by a formal intercollegiate higher assessment which attracts a significant entry fee. There are fewer FTTA's available (22 in all), although with the shortened training period the total number of trainees over a three year period is similar to the old senior registrar numbers. At the end of the FTTA period there is very limited time for the trainee to apply for a consultant appointment. Extensions (if any) beyond the two year training will be discretionary and short. It seems inevitable that some of those completing FTTA will be obliged to enter a period within specialist practice from which they are unlikely to return. These uncertainties combined with centralisation of cleft and potentially orthognathic cases adds further uncertainty about the future role and work load of the consultant.

An academic trainee is somehow meant to find an FTTA and produce a PhD. One of the most successful methods for academic training has been through training fellowships, with the MRC, Wellcome and more recently the MRC together with the Royal Colleges. The first fellowship for an orthodontist was awarded in 1985 and since then at least six more have taken this route. An FTTA for an academic trainee now has to come from the existing numbers, something NHS trainers will find difficulty in accommodating. Either consultants will have to agree to hold their FTTA post vacant in order to attract an academic trainee or an academic trainee will have to start their period of University employment with only a promise that in due course (with the agreement of NHS colleagues) an FTTA slot will be provided for them which will enable them to eventually take their higher specialty examination in orthodontics. Further requirements include a significant publication record, together with the ability to attract grant and overhead income. These additional obstacles could now signal the death of academia, a common cry, but one which would have significant impact on postgraduate training in orthodontics.

The advent of the PDS in orthodontics may be sufficiently financially attractive to shift significant numbers of complex orthodontic cases, traditionally the remit of consultant orthodontists, into specialist practice. The effect of these schemes and possibly the availability of auxiliaries adds further uncertainty. Auxiliaries, if they are to be effective, will require tight regulation, something the GDC and DPB currently have difficulty in addressing. Self regulation by the specialty must be a high priority if it is to remain

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within the GDS. Loss of this service within the NHS could potentially precipitate a crisis in manpower and raises doubts as to how training for private practice would be funded.

If specialist practitioners are to have a greater input to the training of orthodontists, how is this best accommodated. Should trainees spend time in specialist practice during their three year CCST? This seems sensible, but it is another system open to abuse which needs to be clarified. Alternatively, specialist practitioners might have a greater input to existing training programmes? However, this has always been unattractive, it is not possible to pay such individuals more than a consultant sessional rate at the top of scale, which is insufficient to make this 'financially viable'. This would also require specialist practitioners to be involved in subject review and research assessment exercises where they could demonstrate their excellence in teaching and research methodology. Perhaps if the specialty is to undertake these changes, the specialist practitioners should give serious thought as to how they see their role and what should post graduates be taught in the 3 year programme. If it is left to the academics you will be led (as quoted from one eminent professor) by the blind, the sick and the lame.

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